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An exploration of the role of beliefs
(religious, spiritual, and secular)
in pathways of recovery from
problematic substance use.

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Declaration

I declare that this thesis is my original work. It has not been submitted in part or whole for any other degree or professional qualification.

.....
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2016

Abstract

This thesis aims to shed light on the role of religious, spiritual and secular beliefs in individuals' recovery from problematic substance use in Scotland. The findings are based on semi-structured interviews with twenty individuals, living in Scotland, who had past experience of problematic substance use. The methodology was influenced by narrative theory and the analysis drew on a thematic narrative approach. It is suggested that individuals in recovery construct personal belief systems by drawing chiefly on established cultural belief systems. Personal belief systems are learned and reinforced through practice, notably, engaging with belief-orientated communities and practising personal rituals. Participants use their personal belief systems as frameworks to interpret and give meaning to fundamental experiences that were part of their recovery. Personal belief systems are also integral to the construction of identity in recovery, helping individuals to establish a new self or reclaim an idealised past self. While personal belief systems did not often fit within neat religious, spiritual or secular categories, those with religious and/or spiritual beliefs often stressed the importance of their beliefs and associated practices to their recovery. Secular existential beliefs were also important to some people. The implications of these findings are discussed in terms of research, policy and practice.

Dedication

For my past service users and friends who died as a result of their problematic substance use (S., M., L., L., B.), for those who continue to struggle and for those who have overcome.

For Heather and Benjamin, with love.

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This project was a spiritual journey for me. While my God is often a mystery to me, throughout this journey I had the sense of being guided and sustained by him.

List of abbreviations

AA – Alcoholics Anonymous

APA – American Psychiatric Association

CA – Cocaine Anonymous

CBT – Cognitive behavioural therapy

EM – Ethnic minority

NHS – National Health Service

NA – Narcotics Anonymous

SMART – Self-Management and Recovery Training

TNA – Thematic Narrative Analysis

WHO – World Health Organisation

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1 Introduction

1.1 Overview

The problematic use of psychoactive substances by thousands of people in Scotland has had a profound detrimental impact on individuals, families, communities and society (Scottish Government, 2008b, 2009). Individual substance users have experienced the loss of health (physical and mental), financial hardship, relationship breakdowns, homelessness and unemployment related to their excessive use. Scottish society has paid economically in health, social care and criminal justice costs and local communities have experienced fragmentation due to the negative influences of cultures of excessive substance use. Despite the severity and scale of the problems associated with problematic substance use in Scotland, more and more individuals are overcoming their problem and there is a growing nationwide movement promoting recovery (White, 2011; Best et al., 2015). The recovery movement is supported by the Scottish Government through policy and research. However, little research has explored the nature of experiences of recovery in the Scottish context. The aim of this research project is to shed light on the nature of recovery in Scotland. As well as to provide greater knowledge about the factors that are important for individuals in their recovery, it seeks to shed particular light on the role of people's beliefs (religious, spiritual and secular) in experiences of recovery. The primary research question that has guided this thesis has been; what role do beliefs play in individuals' experiences of recovery? Four other questions have emerged as my research has evolved:

- How do individuals construct beliefs in recovery?
- How do individuals practise beliefs in recovery?
- How do individuals integrate beliefs in recovery?
- What are the implications for social work practice?

After discussing the background to this project, in chapter two I will look at the concepts, context, theories and evidence around three main themes of this thesis: problematic substance use, beliefs and recovery. In chapter three I will outline my research design and methodology. In chapter four I present an introduction to my research participants by presenting vignettes of their experiences of problematic substance use and recovery, and by reflecting on their beliefs. In chapter five I discuss how my participants construct beliefs, using the theories of cultural and personal belief systems. In chapters six and seven I explore how my participants practised their beliefs, firstly through engaging with belief-orientated communities, and secondly through practising personal 'spiritual' rituals. In chapters eight and nine I explain how they integrated their beliefs, firstly through meaning-making, and secondly through constructing recovery identities. In the discussion chapter I summarise my findings and comment on the implication of the findings for research, policy and practice.

1.2 Background

My motivation to carry out this research came chiefly through my professional experience of working with drug users, initially in an emergency access homeless hostel, and subsequently in a residential recovery unit. Both facilities were run by organisations that were inspired by Christian values. Part of my motivation for

working with this client group was my desire to practise Christian love. During the years that I worked at the homeless hostel I witnessed at close quarters how individuals' lives could be severely affected by excessive substance use. Different substances had different effects on different people. For some, high levels of substance use could provoke aggressive or violent impulses. Others were driven by an obsession to obtain and use their substance of choice, whatever the obstacles or consequences. Many lost contact with their partners, families or friends due to the impact of their substance use. Some used substances to the detriment of their mental or physical health, leading to conditions such as depression, paranoia, drug-induced psychosis, brain damage, incontinence, liver disease, overdose or death. While I saw some people's lives change with the help of the staff's care and support, we seemed to lose many to their desire for their preferred substances. My faith enabled me to see hope in the midst of these challenges. I believed that God could change lives. I saw some evidence of this in the hostel but I wanted to learn how I could do more to help people with substance use problems.

Motivated by my desire to help people, my Christian beliefs, and a recognition that I needed to be better equipped, I attended a certificate course in addictive behaviour at ISAACS (International Substance Abuse and Addiction Centre of Studies) in Egypt. The course was located at a rehabilitation centre for men with drug and alcohol problems. The centre was run by a Christian organisation, yet in addition to Egyptian Christians (Presbyterian and Coptic Orthodox), the staff team included Muslims. The approach of the organisation combined the Twelve Step philosophy of Alcoholics

Anonymous with psychosocial interventions (e.g. motivational interviewing and cognitive behavioural therapy). Spirituality and the concept of a higher power were important elements of the programme. There were both joint and separate groups for Muslims and Christians. This, to my mind, was an unusual arrangement. It made me question the role of religion and spirituality in the process of recovery.

A year after studying in Egypt, I started working at a Christian recovery centre for men with addiction problems. The centre had a holistic approach to treatment and support, combining one-to-one key working with group-work and peer support, drawing on the Twelve Step model, life skills training, psychosocial methods and Bible teaching and prayer. In the centre I was able to put some of my training to use and put my Christian faith into practice. At this time, I also completed a post-graduate certificate in addictions. This encouraged me to think more about the evidence-base for treatment methods. This, and my experience at the centre, made me think more about the relationship between religion, spirituality and recovery. While I observed individuals' lives changing at the centre, there was not always a clear correlation between change and religion or spirituality. Some of those who changed had done so with the help of their Christian faith. Conversely, some with a Christian faith were not able to enjoy any lasting change, while some seemed to change without any faith or obvious spirituality. These observations raised many questions for me about the nature of recovery in relation to religion and spirituality, promoting me to pursue this research project.

I chose to pursue my research within Social Work at the School of Social and Political Science in the University of Edinburgh. My initial proposal focused on religion and spirituality in relation to recovery from problematic substance use. Over time, my focus broadened to include secular beliefs to incorporate phenomena such as secular spiritualities. My research focus is also concerned with the nature of recovery in *Scotland*, influenced, not just by my long-term residency in Scotland, but by an awareness of the lack of Scottish-based studies. Finally, my motivation is also prompted by a genuine concern for people seeking to recover, and a hope that my research can make a positive difference to how such people are treated and supported in Scotland.

2 Exploring problematic substance use, beliefs and recovery

In this thesis, I am concerned with three key topics: problematic substance use, recovery and beliefs – and their relationship to each other. In this chapter, I will look at each of the key themes in turn, addressing how they may be understood as concepts, how they manifest in the Scottish context and how they have been theorised in academic literature. I will give special attention to the social work perspective on each theme. I will close the chapter by drawing the themes together in a concluding discussion.

Before addressing each topic, I will briefly state why I have chosen to focus on concepts, context and theories. Firstly, understanding how each topic has been conceptualised enables a deeper understanding of their meaning. It cannot be presumed that concepts are neutral or value-free. Rather, as Williams and Soydan (1998) suggest,

Language in use reflects particular theories, values, political ideologies and popular thinking of the day and should therefore properly be the subject of constant review and clarification (3).

Each concept will therefore be examined to reveal how it has been formed and utilised, and the underlying assumptions on which the concept is based. Secondly, I am concerned with context, and particularly the Scottish context. I am presuming that problematic substance use, recovery and beliefs vary from culture to culture,

and that the shape they take in Scotland will differ from that of another context. This idea is central to sociological theory, as Mills (1959) proposes.

[M]an [sic] is a social and historical actor who must be understood, if at all, in close and intricate interplay with the social and historical structures (158).

As well as understanding our present social context, Mills indicates that we must also consider the historical structures that have shaped our society. I will therefore also provide historical context for each of the themes I will discuss. Thirdly, I will examine how my key themes have been theorised. This will provide a context for my research within the existing academic literature. It will enable me to establish how each of the themes has been understood and explained, what has already been established in research and what questions remain (Blaikie, 2010).

2.1 Problematic substance use

2.1.1 Conceptualising problematic substance use

In simple terms, problematic substance use refers to the state that a person experiences when their use of substances (drugs) causes them significant and prolonged life problems. By *substance* I mean a psychoactive drug or substance or, in the words of the *World Health Organisation*, a 'substance that, when ingested, affects mental processes, e.g. cognition or affect' (WHO, 2012). *Use* refers to the means by which drugs are physically consumed by an individual (e.g. eaten, smoked, drunk, injected), and the patterns of behaviour associated with this consumption

(e.g. frequency of use, rituals, social use). *Problematic* indicates that a person's substance use causes them significant (rather than slight) and prolonged (rather than temporary) life problems. In this research I have left the definition of what is problematic for the participant to decide, however commonly recognised problems associated with the habitual and heavy use of drugs include physical and mental health problems, financial problems and social problems (Scottish Government, 2008b; Matthews, 2010).

I have defined substance, to mean a psychoactive substance or drug. Substances can be categorised according to the kind of biological and psychological effects they have on the user e.g. stimulants, depressants or hallucinogens. To understand the social role of any given substance in a specific national context it is helpful to think of substances according to how they are controlled by the state's legislative system. In legislative terms drugs can be categorised as legal, illegal and controlled. In Scotland, legal drugs include alcohol, nicotine and caffeine, and illegal drugs include heroin, cocaine, cannabis, amphetamines and LSD. There are numerous drugs which are state controlled through medical prescription, but which also have a 'street value'. Improper use and distribution of controlled drugs is illegal in Scotland. Within each legislative group, drugs are grouped into classes according to perceived notions of harm (e.g. class, A or B or C). The legal categorisation of substances is closely related to social attitudes towards any given drug.

While I will use the terms *substance* and *drug* interchangeably in the context of this report, *substance* will be my preference. This is because in common usage, *drug* has become the preferred term for illegal substances, not including alcohol. This artificial linguistic division creates a social hierarchy of substances which elevates alcohol into a category of 'less harmful,' while the use of 'street drugs' is associated with social stigma (Singleton, 2011). The evidence suggests that alcohol is the most harmful substance in Scottish society in terms of its impact on health, and national costs to healthcare, social care and criminal justice (Scottish Government, 2009). Some have used the term *alcohol and other drugs* (AOD) to attempt to address this issue (WHO, 2012; White, 2007). However, *substance* has the benefit of being concise and comprehensive, while not supporting the notion that alcohol is somehow set apart.

The concept of problematic substance use is one among many terms used to define how people's use of substances can become harmful to themselves, and to those around them. Problematic substance use is therefore best understood within the context of the cultural discourses which are concerned with drug use. The main discourses which I am referring to are religious, medical, political and legal discourses. The way problematic substance use has been conceptualised has evolved over time, and continues to evolve as social attitudes, institutions and theories about drug use evolve. In the modern era, many words have been used to describe the excessive, compulsive or harmful use of psychoactive substances: inebriety, intemperance, habituation, alcoholism, abuse, misuse, problematic use, dependence and addiction (Maddux and Desmond, 2000). Each term has its roots in a particular

social, cultural and theoretical background and each carries certain epistemological assumptions. The language used to describe the excessive use of substances in pre-modern times was largely defined by religious institutions and communities. The improper use of a substance was defined by the social mores and the moral standards determined largely by religious culture and dogma (Cook, 2006). In the United Kingdom, the influence of religious beliefs and values on how the use of substances was perceived continued to have sway well into the 20th century through the Temperance movement (ibid.). However, in the 20th century the institutions of modern medicine established themselves as the authorities on proper and improper substance use. From a medical perspective, improper use was not seen as an immoral act, it was seen as unhealthy, diseased, disordered or pathological (White, 1998).

In contemporary medical discourse around substances, the *World Health Organisation* (WHO) and the *American Psychiatric Association* (APA) dominate. They have classified problematic substance use in the *International Classification of Diseases* (ICD) and the *Diagnostic and Statistical Manual* (DSM) respectively. The terminology used in the ICD and DSM has evolved over time and is still evolving. *ICD-10* provides clinical descriptions and diagnostic guidelines under the heading, 'mental and behavioural disorders due to psychoactive substance use' (WHO, 1992). The degrees of problematic drug use are defined as acute intoxication, harmful use and dependence syndrome. A range of mental and physiological conditions is also associated with problematic substance use including withdrawal, delirium, psychosis and amnesia. *DSM-5*, released in May 2013 presented a new conceptualisation of

‘substance-related and addictive disorders’ (APA, 2013). The previous categories of substance abuse and substance dependence were superseded by the category of ‘substance use disorder’. This can be measured on a continuum from mild to severe and the specific drug/s involved defines the disorder (e.g. alcohol use disorder, stimulant use disorder). While these changes may not have a big impact on how substance use disorders are classified in the UK, due to continued reliance on *ICD-10* (Petry et al., 2013), the changes illustrate the evolving nature of concepts of problematic substance use.

WHO and APA have a strong influence globally because of the dominance of the English language in ‘addiction science’ (Babor and Hall, 2007). There is still no global consensus about which terms are the most appropriate to describe problematic substance use. Definitions are influenced not just by the evolution of theories of substance use but by the agendas of those using the language, as Babor and Hall (2007) suggests,

[T]here are at times fundamental differences in the goals of the definers that may affect the nature of the definitions. APA is concerned with the clinical management of psychiatric disorders in the United States, whose scientific agenda and mental health services differ substantially from those of other parts of the world. ICD is both a classification system for diseases and disorders and a recording system with important public health functions. Terms such as ‘harmful use’ of alcohol or drugs in ICD have taken on additional public health meanings that go beyond its APA equivalent, ‘substance abuse’, based in part on the need to characterize the problems related to psychoactive substance use at the collective as well as the individual levels (1015).

There is also distance between the use of terms in scientific discourse and those used in everyday life. It takes time for scientific terms to filter down to everyday use and even when this happens, the meaning of terms can easily become blurred (Babor and Hall, 2007). It could be argued, however, that conceptualisations of problematic substance use develop cyclically; scientific terms are built on every day concepts and everyday concepts evolve through the influence of official discourses.

Political and legal institutions have also contributed to the discourse of problematic substance use. The *United Nations Office on Drugs and Crime* (UNODC) for example seeks to control how drugs are produced, trafficked and/or consumed illicitly. They do not distinguish between legal or illegal drugs, but rather aim to prevent the illegal use of drugs according to international law (UNODC, 2016). The Scottish Government's policy on drugs, *The Road to Recovery*, addresses chiefly the illegal use of drugs, but also considers the harms caused by the excessive use of alcohol, nicotine and prescription drugs (Scottish Government, 2008b). The policy primarily uses *problem drug use* and secondarily uses *substance misuse* as preferred terms. The term substance *misuse* may be thought of as preferable to *abuse* which has pejorative connotations (Babor and Hall, 2007: 1016). Yet, misuse could also be thought of as pejorative. Misuse implies that there is a mistaken or incorrect way to use drugs. The boundaries of what is considered correct and incorrect usage are limited by ascribed social, cultural and moral values. In the case of Scottish Government drug policy, presuppositions about acceptable standards of health, the cost of drug use on the economy, the legality of drugs and political rhetoric all contribute to assumptions

about what sort of drug use is correct and incorrect, moral or immoral (Scottish Government, 2008b). The term *substance use* has the benefit of being value-neutral. *Use* does not indicate that there is a right or wrong about taking substances, it simply states that a drug has been consumed.

The term *problematic substance use* is a pragmatic term that should make sense to my research participants, allowing them to make their own decisions about how much of a problem substance use has been for them. They will not need to be concerned about whether they have been formally diagnosed with a 'substance use disorder'. Similarly, it will free the researcher from having to attempt to make any formal diagnosis of a medical disorder. In addition, the term does not presuppose that substance use is compulsive, yet the breadth of the term allows for this possibility.

2.1.2 Problematic substance use in Scotland

Scotland has a long and intimate relationship with psychoactive substances, alcohol being its oldest drug of choice. Alcohol is part of everyday life for many people in Scotland. Drinking alcohol can be a source of pleasure, and it is a pastime around which many people gather. Public houses and bars are at the heart of Scottish social culture and the alcohol industry is a major contributor to the economy (Scottish Government, 2009). Yet, the Scottish Government has concluded that Scotland has an unbalanced relationship with alcohol. Research suggests that consumption of alcohol has increased by 5% since 1994; almost a fifth more alcohol is sold per adult

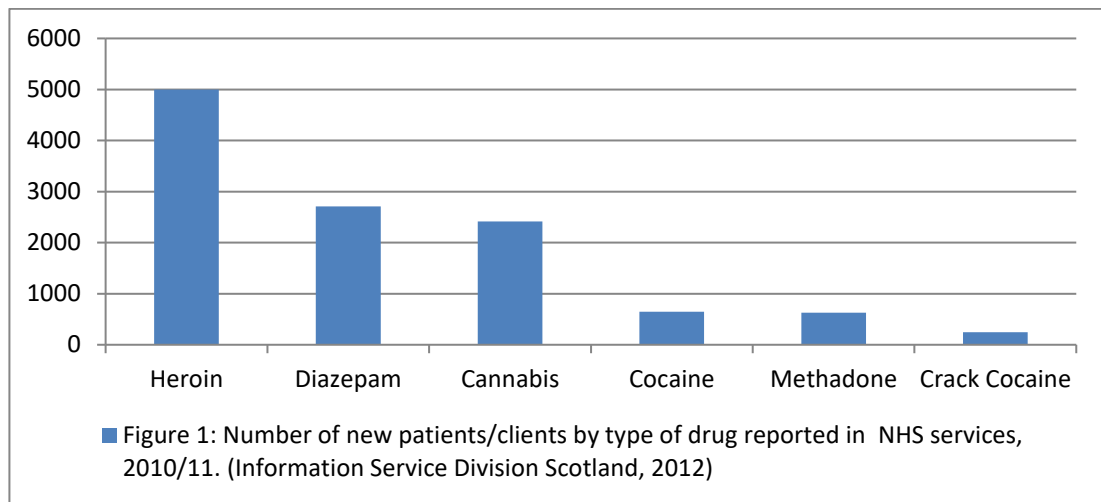
in Scotland than in England and Wales; alcohol-related hospital discharges have quadrupled since the early 1980s; alcohol-related deaths are 1.4 times higher; and 45% of prisoners (including three quarters of young offenders) were drunk at the time of their offence (Scottish Government, 2015b). The Scottish Government has also estimated that excessive consumption of alcohol costs the Scottish economy £3.6 billion each year (ibid.), affecting healthcare, social care, crime, economic productivity and 'the human cost of suffering caused by premature deaths' (Scottish Government, 2010a). Children are also being affected by this cultural trend. Accident and emergency departments in NHS Ayrshire and Arran had 483 accident and emergency attendances for children under 17 years of age with an alcohol-related condition in 2012/13, 'more than any other hospital area in Britain' (BBC, 2013).

During the mid-twentieth century a range of alternative drugs (heroin, cocaine, amphetamines, LSD, psilocybin, MDMA etc.) started to grow in popularity in the UK and drug-using subcultures started to break into the mainstream (Edwards, 2004). Drug taking could be considered a means to personal pleasure, spiritual exploration or social cohesion. Unlike alcohol, such alternative drugs were seen as unacceptable by mainstream institutions and many were criminalised (HMG, 1971). A number of prescription drugs also became subject to statutory control (e.g. benzodiazepines and tranquilisers). It was perceived that such drugs were immoral, harmful, highly addictive and that using them led to anti-social behaviour.

In Scotland today alternative drugs are still a significant, though largely hidden part of Scottish culture. During the 1980s in Scotland, the HIV epidemic highlighted the subculture of intravenous heroin users. Heroin users along with sexually active gay men became the focus of a moral panic (Robertson and Richardson, 2007). During the 1990s, a number of deaths associated with the use of speed and ecstasy in club culture precipitated a similar moral panic in the media (Thompson, 1998). The availability of drugs is in constant flux as new drugs are developed and released on the market. In 2015, 'legal highs' were both growing in popularity and causing moral alarm (e.g. Leask, 2015), and the production, distribution, sale and supply of these was criminalised in May 2016 (BBC, 2016).

It is difficult to ascertain the exact prevalence of the types of drugs that are used in Scotland. The distribution of illegal drugs is largely hidden from society and illicit drugs are usually taken covertly. The use of illegal drugs only really comes to the surface when users are 'caught' by the police or when users seek advice or treatment for problematic drug use. Figures from the *National Health Service* (NHS) in Scotland and the *Information Service Division Scotland* (ISD Scotland) suggest that the most common drugs that became problematic in Scotland are heroin, diazepam, cannabis, cocaine, methadone and crack cocaine (ISD Scotland, 2012; ISD Scotland, 2014 does not provide updated figures). Figure 1 illustrates reported drug use within the NHS in Scotland. These figures give an indication of what kind of drugs are most commonly used in Scotland. However, these statistics only give a partial picture of actual drug use in Scotland. Those reported within the NHS are only, firstly those who accessed

NHS treatment, and secondly, those who were willing to admit what drug they used. The social stigma around the use of illicit drugs may well have discouraged some patients from being open about their drug use (Singleton, 2011).



Findings from the *Scottish Crime and Justice Survey 2012/13: Drug Use* (Scottish Government, 2014a) also give some insight into the nature of drug use in Scotland. Like the figures from NHS Scotland, this data can only give a partial picture. While the research for the survey claimed to be confidential, respondents may have been cautious about sharing information about their use of illegal drugs due to a fear of information being used to incriminate them. The data suggests that in 2012/13, 6.2% of adults reported having used one or more illicit drugs, and 23% had used one or more illicit drug in their lifetime. Overall, the figures from the research indicate a slight decrease in the use of illegal drugs since 2008/9. Cannabis appeared to be the most commonly used drug, though this does not indicate problematic use. The only measure of problematic use explored in the report was dependency. It found that

‘almost a quarter (23.2%) said that they felt dependent upon the drug they used most often in the last month’ (Scottish Government, 2014a: 44).

While many people in Scotland appear to use illegal drugs recreationally without experiencing any evident harm, it is clear that many individuals experience significant life problems linked to their use of drugs. Due to the illegal status of most alternative drugs, government and legal institutions tend to emphasise the harm and overlook any potential benefits of drug use. Similarly, health institutions focus on the pathological side of drug use because healthy users do not come to them for treatment.

According to the Scottish Government, Scotland has an estimated 59,600 individuals with problem drug use (Scottish Government, 2011; 2009-2010 figures), costing society £3.5 billion annually – an increase of £900 million since 2008 (Scottish Government 2008b; 2015a). Shaw et al. (2007) proposed that 80 – 90% of all Scottish prisoners taken into custody have been misusing drugs and/or alcohol. Alternatively, Graham (2007) suggested that 48% of prisoners have a history of drug dependence. More recent evidence noted that 73% of those entering prison tested positive for illegal drug use, including illegal use of prescribed drugs (ISD Scotland, 2012: 40).

A worrying number of deaths has been associated with problem drug use in Scotland. According to the classification set by National Records for Scotland (2015a), 613 drug-related deaths were registered in Scotland in 2014. This was an increase of 16% from 2013 and the largest number ever recorded, 72% higher than in 2004. The majority

of drug-related deaths in 2014 were of males (74%). The drugs that were implicated or potentially contributed to deaths were heroin and/or morphine (50%); methadone (35%); one or more opiates or opioids (including heroin/morphine and methadone) (87%); benzodiazepines (20%); cocaine, ecstasy-type drugs and amphetamines (45, 14 and 22 deaths respectively); alcohol also was implicated in, or potentially contributed to, 106 of the drug-related deaths (National Records for Scotland, 2015a). For alcohol-related deaths alone, there were 1,152 deaths in 2014. This is an increase of 5% compared with 1,100 in 2013, and the third lowest annual total since 1997 (National Records for Scotland, 2015b). A full critique of these statistics is not possible here, but it should be noted that there may be other health factors contributing to drug related deaths.

When surveying problematic substance use, government, legal and health institutions have a tendency to emphasise factors that affect the financial cost to society in terms of impact on the economy, the criminal justice system and health and social care. Yet the most tangible cost of problematic drug use is the suffering experienced by individuals whose lives have become focused on their drug use, together with their families and communities. Problematic substance use in Scotland impacts people's lives in terms of financial hardship, housing difficulties and homelessness, poor physical, mental and spiritual health, crime and social tensions and stigma. These are effects that I have observed in my professional experience of working with drug users. They are also foregrounded by numerous Scottish based reports and studies (e.g. McIntosh and McKeganey, 2002; Matthews, 2010; Singleton,

2011; Best et al., 2013). It must also be noted that problematic substance use does not occur in social isolation. It is often part of a broader landscape of poverty and social inequality (Shaw et al., 2007).

2.1.2.1 Drug and Alcohol Policy in Scotland

The popularity of intravenous heroin use in the 1980s and the associated HIV crisis led to a harm-reduction approach to tackling drug use. Methadone, a synthetic opiate-substitute, was offered to heroin users, as well as clean needles and advice about how to take drugs safely. Methadone prescription was cheaper than other forms of treatment and it was thought to be safer and helped some people to stop the criminal behaviours associated with heroin use:

Replacement prescribing with methadone remains the main plank of medical treatment for opiate dependency in the UK. Harm reduction approaches, incorporating methadone treatment, have evolved rapidly in the face of blood-borne virus infection. It has also been seen to be effective in the Criminal Justice arena by reducing the need for imprisonment (Scottish Advisory Committee on Drug Misuse: Methadone Project Group, 2007: 9)

However, methadone prescribing was a controversial approach for some (Scotsman, 2006; Scottish Government, 2008b). The ideal was considered to be that methadone treatment should be combined with counselling interventions, leading to a drug-free life. In reality, many people remained on methadone indefinitely, some continuing to 'top-up' with heroin. Methadone became another problematic drug that could be highly addictive and dangerous (e.g. contributing the drug-related deaths; National Records for Scotland, 2015a).

In 2008 the Scottish Government introduced a new approach to tackling its drug problem. *The Road to Recovery* moved away from a focus on harm-reduction to promote a recovery-oriented approach (Scottish Government, 2008b). According to the Scottish Government, recovery is:

[A] process through which an individual is enabled to move-on from their problem drug use towards a drug-free life and become an active and contributing member of society (2008b: vi).

The report proposes that all treatment should promote recovery. As the title suggests, recovery is considered to be a journey. Each individual may have a different 'route' to recovery, 'some aim to stabilise the drug user and improve their health, some aim for reduction in drug use, some aim for abstinence' (Scottish Government, 2008b: 26). Other key features highlighted by the report are: treatment should be person-centred; services with different emphases should be more integrated, e.g. mental health, homelessness and employment; there should be a strong emphasis on protecting children and supporting the families of problematic drug users, involving family members in the process of treatment, care and support.

The Scottish Government's model of recovery was not received without criticism. One critic said that it was abstinence in new clothes, and that rather than being person-centred it was economically motivated. He noted the government's idea of recovery 'provides a benevolent rationale for an entirely non-medical imperative – to save money by getting patients out of treatment, off welfare benefits, back to work, and paying taxes' (Ashton, 2008: 1). Further criticism came from an

independent report which stated that the Scottish Government's policy was unclear about what recovery means, how it will work and for not going 'far enough in addressing Scotland's problems' (Matthews, 2010: 6). The independent enquiry team asserted that the Scottish Government's recovery policy will only have a real impact if bureaucracy is combined with 'less tangible but equally important influences that operate in the life of the drug user' (11). It argues further that alcohol and drug problems are 'fundamentally social'; that there needs to be a move away from 'medicalised and criminal justice approaches' towards a more holistic approach focusing 'on purpose and meaning, child and family welfare, employability, family support and community will' (13). The enquiry called for a new dynamic adopting a whole population and personalised approach to supporting those with overwhelming involvement - 'the circle of care' (14).

Soon after the publication of *The Road to Recovery*, the Scottish Government released a new policy on alcohol, *Changing Scotland's Relationship with Alcohol: A Framework for Action* (Scottish Government, 2009). The title implies a recognition that Scotland's relationship with alcohol is somehow problematic, and action is necessary to implement change. The report recognises that many people's relationship with alcohol is 'a balanced, positive and enjoyable one' (6). However, there is also clear evidence that many people in Scotland have a 'damaging and harmful' relationship with alcohol, affecting 'individuals, families, communities and . . . Scotland as a nation' (ibid.). The report specifies the need for a 'long term culture change' (4). It is envisioned that this will happen through legislation, investment in

prevention and treatment services and 'building an environment that supports culture change in the longer term' (6). Sustained action is called for in four main areas: reduced alcohol consumption; supporting families and communities; positive public attitudes, positive choices; and improved treatment and support (5).

The report also aims to work in unison with *The Road to Recovery*. It makes specific mention of *The Road to Recovery* in reference to children affected by parental drug and alcohol misuse (Scottish Government, 2009: 17). Also, in reference to the treatment and support of those with alcohol problems, it promotes joint working between health, local authority and third sector bodies to meet the diverse needs of individuals, 'such as mental health, drug use or housing problems – which may be significant factors in that individual's recovery' (27). Further guidance is recommended via *The Alcohol Problems Support and Treatment Services Framework* (Scottish Executive, 2002) and *National Quality Standards for Substance Misuse in Services* (Scottish Executive, 2007). In recognition of the harm caused by alcohol use, the Scottish Government introduced the *Alcohol (Minimum Pricing) (Scotland) Act 2012* following the belief that raising the price of alcohol would reduce national drinking habits. This Act has still to be implemented after legal challenges from members of the alcohol industry.

Harm-reduction is still integral to drug and alcohol policy in Scotland, but there has been a re-envisioning of how people with drug and alcohol problems should be treated and supported. The Scottish Government has also provided support, financial

and moral, to the *Scottish Recovery Consortium* (SRC). The SRC has led the way in building a national recovery community and supports initiatives to build local recovery communities. One of the pioneering recovery communities has been the *Serenity Café* founded in Edinburgh in 2009.

Scotland is not alone in embracing a recovery approach. The UK Government has made the recovery model central to policy (UKPDC, 2008; HMG, 2010). Australia and the USA have also followed suit (Anex, 2012; White House, 2015). The recovery model seems to have migrated from the USA where the idea has developed through research, particularly from William White and *The Center for the Study of Addiction and Recovery*, and the growth of the American recovery movement (see www.facesandvoicesofrecovery.org).

2.1.3 Theories of problematic substance use

Problematic substance use has been studied within many academic disciplines and each discipline provides a different perspective. Some of the key disciplines in the study of problematic substance use are medicine, psychology, pharmacology, sociology, anthropology, theology, criminal justice and social work. There are a multitude of theories concerning why people use substances and how their use becomes problematic (Orford, 2001a; West, 2001). In this section, I will provide a brief overview of some of the more popular theories of problematic substance use. It will be brief because firstly, it would be impossible to do justice to all the theories of problematic substance use, and secondly, the main focus of my thesis is on how

people recover from problematic substance use rather than why or how their use became problematic. Most theories of problematic substance use can be grouped under the following headings: spiritual and moral theories; biological/biochemical theories; psychological theories; sociological theories; and comprehensive theories.

2.1.3.1 Spiritual and moral theories

Traditionally, in the UK, it was the Christian church that led social discourse about problematic substance use (Cook, 2006). While wine was part of the Christian sacrament of Holy Communion, Christian theology taught that drunkenness was a sin, or in other words, it was immoral. These ideas were central in the temperance movements of the 19th and 20th Centuries. The early temperance movements encouraged moderate, cautious use of alcohol but it evolved to the promotion of abstinence (Paton, 1977). These ideas, which suggested that alcohol is inherently harmful, led to the legal prohibition of alcohol in the USA. This has been defined as the temperance model (Miller and Hester, 2003). Religious ideas have also influenced the development of moral models of problematic substance use (ibid.). Moral models assume that people choose to use substances, that they are morally responsible and should therefore be held accountable for any negative actions resulting from their substance use. These principles are implied in some Christian theology and reflected in the criminal justice systems' punishment of law-breaking drug users and the consequential social stigma faced by users of illegal drugs (Llyod, 2010).

Christian theology also suggests that problematic substance use is a spiritual condition. This idea is still upheld by some Christian academics (e.g. Doweiko, 1999). Some Christian theorists see problematic substance use as a sin, a spiritual sickness that can only be remedied through a spiritual path (Smith and Playfair, 1992). The spiritual model of problematic substance use has been popularised by Alcoholics Anonymous. It traditionally teaches that alcoholism can only be overcome through recognising one's powerlessness, turning one's will and life over to a higher power and having a spiritual awakening (Alcoholics Anonymous, 2013). This model has been applied to other drugs through Narcotics Anonymous (NA) and other Twelve Step fellowships.

2.1.3.2 Biological / biochemical theories

One of the most influential theories of problematic substance use is the dispositional disease model, commonly called the disease model. In the disease model, the alcoholic or drug addict is constitutionally different from the 'normal' person. Their condition means they are incapable of moderate substance use. Their disease is presumed to be irreversible and incurable but the condition can be controlled through total abstinence. The substance is not the core of the problem, rather the problem lies with the physical and psychological make-up of the alcoholic. The disease model is particularly popular in the USA and has become associated with Twelve Step fellowships. While there seems to be little scientific evidence for the disease model, it has some popularity in the medical profession because it medicalises problematic substance use (Miller and Hester, 2003).

Biological models, sometimes used to support the disease model, emerged in the 1970s and they focused on the 'genetic and physiological processes as determinants' for problematic substance use (Miller and Hester, 2003: 4). In alcohol-focused research, links were made between intergenerational genetic characteristics and higher susceptibility to alcoholism. Other studies highlighted biological characteristics such as abnormal alcohol metabolism or unique brain sensitivity that predisposed some individuals to alcoholism. Knowledge about the pharmacology of alcohol was also used to explain how alcoholism can develop (ibid.)

Biochemical theories that focused on opiate use looked for physiological deficiencies or specific metabolic changes brought on by drug use. The biochemical view presupposes that the addict is biochemically deficient or malfunctioning and needs the correct medical treatment for their system to be corrected (Biernacki, 1986). There has been a trend in recent scholarship towards an interest in the relationship between brain chemistry and drug addiction (Koob et al., 2014).

2.1.3.3 Psychological theories

Psychological theories tend to locate the cause of problematic substance use in individual's personality or character. Addictive personality theory is a popularised example of a psychological theory (Nathan, 1988). In traditional psychoanalytic theory, the aetiology of such 'disorders' is often assumed to be rooted in problematic family relations during childhood. Individuals will remain pathological until their deficits can be corrected through therapeutic interventions (Biernacki, 1986). Miller

and Hester (2003) define this as the characterological model. Other psychological theories propose that drug using behaviours are learned through behavioural conditioning, social learning or internal cognitive processes (ibid.). The popularity of cognitive behavioural therapies in treating problematic substance use highlights the popularity of cognitive psychology in the drug treatment field (Best et al., 2010; McHugh, et al., 2010). There has also been a growing interest in the effects of trauma on drug-using behaviours (Etherington, 2008; Hammersley and Dalgarno, 2013). Other prominent psychological theories are Orford's theory of addiction as excessive appetites (Orford, 2001a, 2001b) and West's synthetic theory of motivation (West, 2006).

2.1.3.4 Sociological and anthropological theories

Sociological and anthropological views see the problems that drug users experience coming primarily from their social context or culture. One of the most influential sociological/anthropological studies of drug use is *Outsiders* by Howard Becker (1973; first edition 1963). Becker, in his study of marihuana users within a dance music subculture in North America, theorised how drug users were labelled as outsiders and deviants by mainstream society. Within their own group, marihuana users found acceptance and experienced social cohesion. In society at large they were pathologised and criminalised. Their drug use was perceived as problematic because of how they were labelled as 'deviant'. While much more could be said about the implications of Becker's theory; it illustrates how social attitudes towards drug use can impact drug-using culture and potentially problematise it. Another example of a

sociological theory, related to Becker's analysis, is identity theory. Identity theory sees a person's problematic substance use as evolving from identification and engagement with a drug-using environment or cultural group (Young, 1971; Biernacki, 1986; Anderson, 1994; White, 1996).

2.1.3.5 Comprehensive theories

A number of theorists have attempted to construct theories of problematic substance use which cover multiple dimensions. Zinberg's (1984) theory of drug, set and setting remains one of the most cited. Zinberg thought that to understand the impact of drug use on a person, one must take into account the drug (its nature and biochemical effects), the set (the nature of the user and their psychological expectations in using) and the setting (the range of social, cultural and environmental factors involved in the act of using). Another prevalent example is the biopsychosocial model, which is an attempt to integrate biological, psychological and social theories (Engel, 1980).

2.1.4 Social work and problematic substance use

There is a wide range of professionals who work to help those who suffer from problematic substance use: medical doctors, nurses, psychologists, counsellors, social workers, housing officers, peer-support workers and social care workers, amongst others. There are also several different kinds of organisations in which such work is delivered: NHS, statutory, and those supported by the private and voluntary sectors. While many substance workers are highly trained professionals, some

workers are low-paid staff who may have minimal training or support (e.g. social care workers, peer-support workers). Social workers play a key role in delivering care and support to people with substance use problems, in partnership with other professionals. Social work, according to the International Federation of Social Workers (IFSW) is,

a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing (IFSW, 2014).

The meaning of social work is not fixed. Rather it varies between contexts (global and local) and over time (Cree, 2013b; Cree and Myers, 2008). In Scotland, it could be argued that, in line with the IFSW definition, different types of professionals perform the tasks of a social worker, such as social care workers and community workers. However, in Scotland, the title of social worker is protected, reserved for those with specific training (usually a Bachelor's or Master's degree in social work) and membership of the *Scottish Social Services Council*. While some social workers in Scotland work for voluntary and private sector organisations, the majority are employed by the state. The Scottish Government (Scottish Executive, 2006a) use Asquith et al. (2005) to explain their perspective on social work. Asquith et al (2005) identify the role of the social worker in the following descriptive points.

- *case worker* working with individuals to help them address personal issues;

- *advocate* on behalf of the poor and socially excluded;
- *partner* working together with disadvantaged or disempowered individuals and groups;
- *assessor of risk or need* for a number of client groups; also associated with surveillance;
- *care manager* who arranges services for users in a mixed economy of care, but may have little direct client contact; and
- *agent of social control* who helps to maintain the social system against the demands of individuals whose behaviour is problematic. (Asquith et al., 2005 in Scottish Executive, 2006a: 28, 29)

The Scottish Government suggests that these roles are to be carried out through building therapeutic relationships with clients (Scottish Executive, 2006a). The role of the social worker in Scotland therefore involves a certain paradox. The social worker is meant to advocate, empower, protect and promote social justice, but also be the state's agent of social control.

Social workers in Scotland commonly encounter people with substance use problems in a range of practice contexts: in children and families work; in connection with mental ill-health and domestic violence; and in youth and criminal justice work (Galvani, 2012: 7; Scottish Executive, 2006b). The complex needs presented by people with substance use problems, present a challenge to social work in Scotland:

People with substance misuse problems have needs which cross service boundaries, further challenging services to develop personalised approaches that make effective use of specialist expertise while meeting people's health needs, addressing the impact of the substance misuse on children and families and protecting the community from any associated offending behaviour (Scottish Executive, 2006a: 24).

The relevance of social work, in working with people with substance use problems, and the challenges it faces, is illustrated in the tragic case of Caleb Ness. Caleb was an 11-week-old baby whose mother was a 'recovering heroin addict' (Cramb, 2003). Caleb became physically addicted to methadone when his mother was pregnant with him. His father shook Caleb to death when his mother was taking a prescription to the chemist. Health and social workers had been aware that Caleb was at risk of harm. An independent inquiry concluded that Caleb's workers failed to act despite numerous opportunities (O'Brien et al., 2003). Irrespective of the rights and wrongs of this case (e.g. demonising drug users, scapegoating professionals), it illustrates both the necessity for social work involvement and the complexities they face in working with people with substance use problems.

2.2 Beliefs

In this thesis, I am concerned with the role of *beliefs* (religious, spiritual and secular) in pathways of recovery from problematic substance use. In general usage, belief can be thought of as the acceptance that something is thought to be true. My use of the term refers to what could be more precisely be termed *existential beliefs*¹, or beliefs which concern the nature of one's existence and one's purpose and meaning in life. In the literature about recovery pathways, beliefs have been categorised as religious, spiritual or secular (White and Kurtz, 2006; Best et al., 2010). In this chapter I will

¹ Not to be confused with existentialism - I chose not to include existential in the title of the thesis to avoid this association.

investigate how each of these types of belief have been conceptualised, outline the types of beliefs found in Scotland, and discuss the relevance of beliefs to social work.

2.2.1 Religious belief

Religion is a concept that has been repeatedly contested by many academics including religious studies scholars, sociologists, psychologists and anthropologists (Braun and McCutcheon, 2000). Each academic discipline functions as a lens through which religion is understood. Each description of religion is influenced by the bias, language, values, epistemologies and history of each discipline, and within each discipline individual academics have their own perspectives on the meanings of religion.

It has been suggested that religion is 'a phantom-like category, a spector' (Braun and McCutcheon, 2000: 3). While religion consists of objective social interactions, institutions, rituals and language, when examined, its form seems to become fluid and hard to grasp. Jonathan Z. Smith argues that religion does not exist outside of its academic study, it is 'created for the scholar's analytic purposes by his [and her] imaginative acts of comparison and generalization' (Smith, 1982: xi).

In practice, views of what religion means and consists of vary considerably. Some have argued that religion is a Western, Christian concept that does not fit readily with the non-Western cultures (Smith, 1993; Assad, 1993). To think of religion as a universal or essential category is therefore flawed. Cultural traditions, beliefs and practices are founded in particular cultural contexts, and are influenced by history,

social groups, institutions and 'the way power is legitimized and organised' (Fitzgerald, 2000: 71; Masuzawa, 2005).

Arnal (2000) suggests that because religion is a popular term, it is sometimes assumed that religion is a 'common sense' category that needs no definition. He uses the work of Karl Marx (1818-1883) and Sigmund Freud (1856-1939) to illustrate this point. Marx and Freud produced some of the most influential theories of religion, yet they do not provide any clear definition and the way they describe it shows conflicting and inconsistent conceptions of religion. Marx's descriptions of religion vary from an 'inverted world-consciousness,' a 'general basis of consolation and justification,' to the 'spiritual aroma' of the world (Arnal, 2000: 22). Arnal suggests that Marx's theory is that 'religion *is* some sort of affect-laden intellection,' the subject matter of which he circumscribes in differing and mutually exclusive ways (Arnal, 2000: 22). Freud's description of religion also seems to show inconsistencies. For Freud, religion is sometimes, 'a set of (false) *beliefs* . . . delimited in terms of their supernaturalism,' and sometimes, 'it is constituted by a set of (ritualistic and obsessional) practices' (Ibid.). What these examples also illustrate is the connection between definition and theory. A definition of religion, or what religion *is*, is informed by a theory of religion, or what religion *does*. In turn, how religion is theorised is dependent on how religion is defined.

Arnal (2000) surveys how religion is defined by some of the most influential scholars in the history of religious studies. F. Max Muller (1823-1900), thought to be the founder of modern religious studies, defined religion as,

the primitive intuition and adoration of God, “perception of the infinite,” the natural and transcultural awareness that some Other is responsible for one’s own existence and that of the world (Arnal, 2000: 23).

The pioneers of the anthropological study of religion, E. B. Taylor (1832-1917) and J. G. Frazer (1854-1941), thought of religion in terms of mental belief in spiritual beings, or ‘powers believed to be superior to man’ (ibid.). They categorised the way people understand the world as magical, religious or scientific. Frazer saw these as ‘successive stages in human intellectual evolution’ (ibid.).

Muller’s, Taylor’s and Frazer’s definitions are all characterised by an *intellectualist* approach, which can be traced to David Hume (1759-1838) and the Enlightenment². In the intellectualist approach religious dogma is contrasted with rational, scientific knowledge. Religious belief is understood through the philosophical lens of Enlightenment thinking, but is also influenced by the politics of the Enlightenment which tested ecclesiastical institutions and religious absolutisms through rational critique (Arnal, 2000). Arnal proposes that religion is therefore an ‘intellectual

² The Enlightenment was an intellectual and cultural movement in Europe during the 17th and 18th centuries that championed the power of reason, furthered humanistic thought and challenged traditional ideas about God.

invention of modernity' (23). Hence, to understand religion, one must understand the socio-political environment in which it is rooted.

The intellectualist approach focused on the content of belief. Another tradition that developed in the study of religion is the *functionalist* approach. Functionalists look at *how* people believe and what role belief plays in people's lives. Functionalism considers the extra intellectual elements of religion including emotions, behaviours and consequences (Arnal, 2000). Emile Durkheim's (1858-1917), *The Elementary Forms of Religious life* (Durkheim, 1995) is exemplary of the functionalist approach. Durkheim was interested chiefly in the social functions of religion. He used the idea of totemism to explain primitive forms of religious belief and practice. He also made a distinction between the sacred and the profane which are arbitrary categories dependent on their social context. Durkheim defined religion as, 'a unified system of beliefs and practices relative to *sacred things*, that is to say, set apart and forbidden' (Durkheim, 1995: 44). It could be argued that Freud and Marx also take a functionalist approach to religion. Freud attested that religion provided 'a neurotic outlet for the social necessity of the repression of anti-social drives,' and Marx's work indicates that the function of religion is to 'occlude the truth and provide mystic consolation for the afflictions of this world' (Arnal, 2000: 25).

Another perspective on religion is shared by Rudolf Otto (1869-1937) and Mircea Eliade (1907-1986). They understood religion as the expression of an 'irrepressible human instinct, and impulse towards the ultimate or infinite' (Arnal, 2000: 25). While

a functionalist approach reduces religious experience to its social, psychological or material functions, Otto and Eliade sought to uphold the *reality* of the numinous³. This has been categorised as a substantivist perspective.

It needs to be acknowledged that religion is essentially an artificial concept and that attempts to define it portray elements of bias (Smith, 1990). However, if the features of the social world that are commonly characterised as religious are to be studied, then a working definition is necessary. James Cox (2010) proffers a definition that attempts to surpass essentialist notions and encompass substantivist and functionalist perspectives:

Religion refers to identifiable communities which base their acts of believing and their resulting communal experiences of postulated non-falsifiable alternate realities on a tradition that they legitimate by appealing to its authoritative transmission from generation to generation (Cox, 2010: 17).

The first feature of Cox's definition is *identifiable communities*. Religion is characterised by distinguishable communities, 'embedded in shared social constructs that are codified, symbolized and institutionalized' (Cox, 2010: 14, 15). These communities are centred on *acts of believing* consisting of 'cognitions, thoughts, ideas, concepts, world-views' (15). Flowing out of these beliefs, members communally experience what Cox calls *experiences of postulated non-falsifiable alternative realities* – this is the feature that distinguishes religious communities from

³ The supernatural.

secular communities. Religious communities assume and *experience* the existence and presence of other-worldly realities (God, gods, spirits, demons, ancestors). Cox emphasises that, 'believers do the postulating, not the scholars' (16). His use of the term *non-falsifiable* frees the scholar from making any judgement on the reality of what believers postulate. Finally, religion can be distinguished by being rooted in a tradition that is the basis for religious authority and which is passed down through the generations⁴.

2.2.2 Spiritual belief

Conceptualisations of spirituality are perhaps even more highly contested than those of religion. In the 21st century, spirituality has become a topic of growing interest. This is clear from the growing catalogue of academic literature on the topic from a range of disciplines (Holmes, 2007; Sutcliffe and Bowman, 2000; Swinton, 2001; Gorsuch, 2002; Giacalone and Jurkiewicz, 2002; Carrette and King, 2005; Heelas and Woodhead, 2005; Heelas, 2008; King, 2009; Knoblauch, 2010; Holloway and Moss, 2010).

While spirituality could be thought of as a post-modern concept (Griffin, 1988; Jankowski, 2002), it has historical roots in religious tradition. Spirituality is rooted in *mysticism* which King (2009: 306) describes as 'those aspects of the various religious traditions which emphasise unmediated experience of oneness with the ultimate

⁴ See chapter five for further discussion of religion

reality'. King proposes that the term *spirituality* has been favoured over *mysticism* as a reflection of the West's 'more individualistic and less tradition-bound approach to the mystical', the cultural trends of secularisation and the 'de-traditionalization' of religion (ibid.). This is confirmed in Grace Davies' thesis, that belief today is characterised by 'believing without belonging' (Davie, 1994).

The term 'spirituality' has been used to describe a plethora of activities, experiences and attitudes such as yoga, special diets, monasticism, generosity, occultism, non-violence, pietism, and stigmata, to name a few (Stringfellow, 1984: 19). Swinton (2001) suggests that spirituality is a 'slippery concept'. While religion and spirituality are distinct concepts, they sometimes overlap. Some definitions of spirituality are implicitly religious while others are humanistic. The phrase, 'spiritual but not religious' has become an increasingly popular idea (Perrin, 2000; King, 2009). For many people religion, and especially religious institutions, have negative associations yet they want to hold on to that which is spiritual. Swinton suggests that spirituality is a universal element of all humanity, 'The human spirit is the essential life-force that undergirds, motivates and vitalizes human existence. *Spirituality* is the specific way in which individuals and communities respond to the experience of the spirit' (Swinton 2001: 12).

The idea of spirituality as a universal element of human nature has been embraced by many religionists, academics and members of the public. Some have embraced this idea as the core of a secular or humanistic spirituality (Giordan, 2007). Chris Cook

(2004), in his review of the literature which discussed spirituality and substance addiction, compiling a list of the common themes and drawing them together in an attempt to construct a comprehensive definition of spirituality. His summation was that spirituality is,

a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately 'inner', immanent and personal, within the self and others, and/or as relationship with that which is wholly 'other', transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values (548).

Cook's definition enables both religious and humanistic understandings of spirituality. The definition covers both spiritual experience in terms of the inner life and interaction with communities or social traditions. It incorporates spirituality as relationship with the self and that which is other (e.g. God). It also associates spirituality with the existential and moral matters of meaning, purpose, truth and values.

Spirituality can be a confusing concept because of the various ways it has been used in relation to religious traditions and secular philosophies. As Sheldrake (2012: 22) points out, 'spirituality is inherently related to context and culture'. However, there are some common themes in popular understandings of spirituality, such as holism, a quest for the sacred, a focus on meaning and purpose and being anti-authoritarian (Sheldrake 2012).

2.2.3 Secular belief

Secular is normally defined by what it is not. It is that which is *other* than religious.

According to Martin and McFerran (2008) secular beliefs are,

non-religious beliefs that reflect an emphasis on living in the here and now. Secularists use scepticism and rationalism to question traditional religious beliefs; they may be humanists, atheists, deists (believing in a creative force, or first cause), or agnostics.

Secular beliefs have emerged from processes of secularisation which have their roots in the Enlightenment and the philosophy of scientific rationalism. Secularisation consists of the 'differentiation of the secular spheres from religious institutions and norms . . . decline of religious beliefs and practices, and . . . marginalization of religion to a privatized sphere' (Dobbelaere, in Davie 2007: 51). While there is much debate about the influence and form of secularisation, it is clear that a growing number of people in Scotland have secular beliefs (National Records for Scotland, 2013). Common contemporary secular beliefs include atheism, agnosticism, secular humanism and existentialism.

In recent times atheism in particular has grown in popularity through the works of Richard Dawkins, Christopher Hitchens, Sam Harris, Daniel Dennet and A. C. Grayling. This belief has been called the *New Atheism* (Amarasingam, 2010). Atheism in its literal sense means *without deity*, or 'the denial of the existence of any god or gods' (Martin in Cliteur, 2010: 26). In other words, it is 'an attitude of scepticism towards claims of the existence of any sort of God or gods' (Cooke in Cliteur, 2010: 26). For

some, atheism may include scepticism or disbelief in 'the existence of immortal souls, life after death, ghosts, or supernatural powers' (Baggini in Cliteur, 2010: 33). This idea of atheism may be thought of as *negative atheism* because it is defined by what it is not. It might be thought of as an anti-belief more than a belief. Agnosticism is similar in that it focuses on the negative. Agnosticism is 'the theory according to which things in a specific realm cannot be known' (Cliteur, 2010: 50). The *specific realm* need not be religious but agnosticism is most commonly applied to the existence of God or gods. Sweetman has suggested that there is also a *positive atheism*, which he identifies with secularism:

Nowdays, a secularist is much more likely to present secularism as a positive thesis, one that identifies what he believes, rather than what he does not believe . . . secularists will say they believe that human life is the outcome of purely random, naturalistic process (evolution), and that all reality is physical. And, very important, their defense of these claims will not now consist simply of attacking arguments for religious belief: they will try to offer positive arguments to support these views (Sweetman in Cliteur, 2010: 36).

A. C. Grayling, recognising the negativity of atheism as a term, proposes that the *naturalist* should be the preferred term, 'denoting one who takes it that the universe is a natural realm, governed by nature's laws' (Grayling, 2016). Paul Kurtz (1997) favours the term humanism, which he explains as eupraxophy:

Specifically, it advocates a cosmic outlook based upon science and philosophy and a practical ethical approach to the good life. Unlike theoretical science, which seeks to explain how nature operates, or pure philosophy, which is concerned with analysis, eupraxophy attempts to apply knowledge to practical normative issues. I especially wish to contrast humanistic eupraxophy with both

transcendental theistic religion, which often considers the highest moral virtues to be faith, hope and charity, and the sceptical nihilistic attitude, which denies that there are any objective grounds for the moral virtues (2).

Fowler (1999) argues that the definition of humanism is ever changing depending on how each person interprets their own distinct form of humanity. However, as a working definition she suggests the definition provided by the *International Humanist and Ethical Union*:

Humanism is a democratic and ethical life stance which affirms that human beings have the right and responsibility to give meaning and shape to their lives. It stands for the building of a more humane society through an ethics based on human and other natural values in a spirit of reason and free inquiry through human capabilities. It is not theistic, and does not accept supernatural views of reality (Fowler, 1999: 11).

This statement describes secular humanism but there are other forms of humanism. Christian humanism tends to emphasise the humanity of Jesus. Confusingly, there are theistic and non-theistic forms of Christian humanism. Secular beliefs also encompass what have been called quasi-religions such as Marxism or nationalism (Smith, 1994), and as I have discussed in the previous section, contrary to popular notions, spirituality can also be framed in secular terms.

Existentialism is a term that covers various philosophies that can be traced back to Søren Kierkegaard (1813 - 1855) and Friedrich Nietzsche (1844 – 1900). It was popularised in mid-twentieth century Europe by Jean Paul Sartre (1905 – 1980) and his associates, including Simone de Beauvoir and Albert Camus. It also had an impact

on movements within psychology and theology. Existentialism is not a single philosophy that can be easily defined. It has been associated with ideas of authenticity, 'dread, boredom, alienation, the absurd, freedom, commitment, nothingness' (Crowell, 2015). Secular existentialism presumes that there is no God, and individuals are the authors of their own destiny (Lookstein, 1957).

2.2.4 Beliefs in Scotland

Existential beliefs have been integral to Scotland's history. They have been sources of dramatic social change and fraught cultural conflicts. Religion in particular has played a key role in shaping modern Scotland (Brown, 1997). Scotland's history is rooted in early forms of pagan spirituality, which still has influence in Scotland today, but it is the Christian religion which has had the largest impact on Scottish history and culture. From the 4th century AD Christianity gradually gained influence through early forms of 'Celtic' Christianity. Celtic Christianity was superseded by Roman Catholicism from around the 7th century (MacKenzie, 1936). In the 16th century the Scottish Reformation brought Protestantism to Scotland. Presbyterianism and Calvinism in particular are often considered to be synonymous with religion in Scotland (MacLean and Veitch, 2006; Brooke, 1999).

The rise of Protestantism during the Scottish Reformation brought antagonism between Roman Catholics and Protestants. In the 19th and early 20th Century there was systematic discrimination against Roman Catholics (Brown, 1997). Sectarianism became a defining feature of Scottish culture, still overshadowing aspects of

contemporary Scottish society (Bruce et al., 2004; Rosie, 2004). While Scotland may no longer be systematically sectarian, bigotry and prejudice is still evident in Scottish football culture (BBC, 2011). There may also be a perception that religious conflict is still a real part of Scottish life, as Rosie (2004) proposes,

there is a widespread perception that religious conflict remains a problem in Scottish society. In this 'subjective' sense, many Scots seem to believe that religion still matters in a negative and divisive way . . . Scotland is not a sectarian country . . . but concern about religious conflict and religious difference seems widespread (39).

It could be argued that sectarianism has made some people cynical of institutional Christianity, making it a cultural taboo. This may partly explain why many Scots have turned away from the traditional churches. Recent revelations of child abuse perpetrated by Christian clergy has also tarnished the reputation of Christianity in Scotland (e.g. Daly, 2015).

While Christianity has been a major influence in Scotland, Scotland has also been a centre for secular thought. Scotland was one of the centres of Enlightenment thought during the 17th and 18th centuries that championed the power of reason, furthered humanistic thought and challenged traditional ideas about God (Herman, 2003). Secular thought has gained more influence during the early 20th century. This process is commonly known as secularisation. Bruce et al. (2004) suggests that, '[c]hanges in the Scottish economy, polity and society since the late 1930s have reduced the importance of religious and ethnic identity to a point of irrelevance' (172, 173).

Church attendance declined dramatically from the 1960s and has been decreasing steadily in recent years (Bruce et al. 2004; National Records for Scotland 2013).

Belief in Scotland changed dramatically during the 20th century and it seems that the process of secularisation is continuing to take effect as the 21st century progresses. Just over half (54%) of the Scottish population now consider themselves to be Christians. This is a 11% decrease since 2001. 37% of people identified themselves as of no religion, a 9% increase since 2001 (National Records for Scotland, 2013). Scotland's landscape of belief is also changing due to the increase of the minority ethnic populations, many of whom hold belief systems not traditional in Scotland. Scotland's minority ethnic population has doubled since 2001 from 2% to 4% (ibid.). People from an Asian background represent the largest minority ethnic group (3% or 141,000 people). Urban centres have the highest level of ethnic minorities (Glasgow, 12%; Edinburgh and Aberdeen, 8%; Dundee, 6%). Scotland's Muslim population has grown to 1.4% of the population (an increase of 0.6% since 2001) and the numbers of those ascribing to Buddhism, Hinduism and Sikhism have also grown (0.7%; ibid.). Roman Catholicism has also been stabilised through the support of the Polish population (1.2%) and other eastern European groups with traditionally Catholic cultures (ibid.). Islam in particular has had gained a controversial image in Scotland through media discourses around fundamentalism and radicalisation (e.g. Herald Scotland, 2016).

Secular philosophies, sectarianism and increased ethnic diversity in Scotland have all impacted on Scotland's belief landscape and especially on how Christianity is perceived. A recent report suggested that many people in Scotland see the Christian church as 'not compatible with science' (23%), 'judgmental' (21%), 'out of touch with reality' (20%) and 'hypocritical' (20%) (Barna, 2015). Scotland's belief landscape is continually evolving as society and culture changes. Many people do not fit into the traditional religious categories or the non-religious categories of humanist, atheist or agnostic. The transference of information through the processes and technologies of globalisation has opened up access to many alternative belief systems and spiritualities. Something of the diversity of beliefs represented by the inhabitants of Scotland can be glimpsed through the various expressions of spiritual identity found on the internet⁵. Figure 2 lists a selection of contemporary Scottish spiritual organisations, communities and festivals. Influences include Celtic and monastic Christianity, New Age and esoteric spirituality, and humanism and interfaith philosophies. The presence of these groups illustrates the diversity of beliefs in Scotland.

Figure 2. – Expressions of 'spiritual' belief in Scotland

- The Way of the Shaman
 - Humanist Society Scotland
 - Findhorn Foundation
 - The Ignatian Spirituality Centre
 - Sacred Connections
-

⁵ Using the search terms 'Scotland' and 'spirituality'.

- Scottish Centre for Interfaith and Spirituality
- The Esoteric Retreat Centre
- Iona Community
- Glasgow Association of Spiritualists
- Edinburgh International Festival of Middle Eastern Spirituality and Peace

It is clear that people who live in Scotland are influenced by the beliefs represented in Scottish history (Christianity, paganism and humanism), but also by the beliefs transported through processes of immigration and the globalisation of information. Sectarianism may also have played a significant role in turning people away from traditional forms of Christianity and seeking alternative forms of belief and spirituality. Buddhism and other Eastern philosophies in particular seemed to have gained popular influence through the dissemination of spiritual ‘therapeutic’ practices such as yoga, meditation (or mindfulness), Tai Chi, reiki and acupuncture.

2.2.5 Social work and beliefs

Contemporary social work in the UK is largely a secular profession, drawing on psychological, political and sociological theories (Payne, 2005). It draws inspiration from a range of secular existential and political ideologies including humanism, feminism, socialism and anti-racism. Many of the core values of social work, such as human worth, respect, equality and valuing diversity, come from these ideologies (Banks, 2012). While current professional social work practice in Scotland may be secular in nature, its historical roots are explicitly Christian (Cree, 1996). Many voluntary sector organisations that provide social services also have Christian roots, and some still consciously take inspiration from Christian values and principles (e.g.

Barnardos, Cyrenians, Salvation Army). Also, many social workers are people of religious or spiritual persuasion (e.g. the existence of a *Social Workers Christian Fellowship* demonstrates this) and their non-secular beliefs can be a source of motivation and resilience in professional practice.

Beliefs take on particular importance to social work practice when working with service users. Considering the religious and spiritual beliefs of service users is recommended in relevant legislation, policy and research (HMG, 1995; Myers et al., 2005; Best et al, 2010; Scottish Government, 2008a). Two examples relate to children and those with mental ill health. The *Children (Scotland) Act* (HMG, 1995) states that, in considering taking a child into care that the local authority 'shall have regard so far as practicable . . . to the child's religious persuasion, racial origin and cultural and linguistic background' (15). In relation to mental health, NHS Scotland proposes that,

Scotland is a religiously and culturally diverse country. We need to recognise this to address the spiritual and religious needs of people we support in mental health services (NHS Education for Scotland, 2011: 95).

However, the lack of discussion about spirituality and religion in general social work legislation, policy and research may suggest that it is assumed that they are relevant only for highly vulnerable or pathological groups: children; people with mental ill health; people in recovery from problematic substance use; and those at the end of their lives.

According to Payne (2005), the secular shape of social work in the UK and Scotland is also changing in response to three key influences. The first key influence is Scotland's growing minority ethnic population (National Records for Scotland, 2013). Service users now represent an increasingly diverse range of religions and beliefs. This brings challenges to social workers when considering how to best understand and support people who hold different beliefs, beliefs which are perhaps contrary or incomprehensible to their own (Payne, 2005; Furness and Gilligan, 2010). For most non-Western cultures, religion and spirituality are universal concerns. This has relevance for social work practice with minority ethnic groups in particular, but may also have relevance for the general Scottish population, as Payne (2005) suggests, 'social work with individuals often raises or deals with spiritual issues in people's lives' (183). A growing number of immigrants are also becoming social workers, bringing to social work their own cultural beliefs and values (Hillen, 2013).

The second key influence is the globalisation of social work. Combined with the ethnic diversification of Scotland, the shrinking of the global community of social workers, enabled through communication technologies, is forcing social workers to have a global perspective (Castells, 1996; Cree, 2013a). Since social work in other cultures often has strong religious affiliations or spiritual elements, social workers in Scotland are being challenged to re-evaluate their theory and practice (Patel et al., 1998; Payne, 2005; Furness and Gilligan, 2010).

The third key influence that is challenging the secular nature of social work is the growing discourse around religion and spirituality in social work literature. Payne argues that religion and spirituality does not necessarily fit well with 'modernist assumptions of evidence-based professionalism' (Payne, 2005: 181). However, an increasing number of social work educators, practitioners and researchers affirm the importance of considering religion and spirituality in social work, especially in working with ethnic minorities (Patel et al., 1996; Furness and Gilligan, 2010; Holloway and Moss, 2010).

Since the mid-1990s, there has been immense growth in the amount of social work literature discussing spirituality in particular (Bullis, 1996; Crompton, 1996; Canda, 1998; Canda and Smith, 2001; Derezotes, 2006; Matthews, 2009; Canda and Furman, 2010; Crisp, 2010; Holloway and Moss, 2010; *Journal of Religion and Spirituality in Social Work*). This is perhaps a reflection of the interest in spirituality in society in general (Theos, 2013). Payne (2005) suggests three other reasons for the growing interest in spirituality. He suggests that there is a political interest in including religious communities in the provision of care and the operation of community services, because of a belief that they contribute to social stability. He adds that this is also an imperative because there is some evidence that religious involvement can prevent some social ills (e.g. Hodge et al., 2007). Encouraging faith communities to take more responsibility for social care also fits with the UK government's Big Society agenda (Shorthouse, 2016). Payne also believes that the new focus on spirituality is a reaction to the West's culture of materialism, consumerism and commodification.

Finally, Payne adds that spirituality fits with social work's holistic/ecological model (e.g. Okundaye et al., 1999; Wolf, 2003). Payne believes that social work's ecological perspective is inherently humanistic and spiritual. The whole person is considered in relation to her/his social and physical environment, respecting the person's 'understanding and interpretation of their experience' (2005, 205). Spirituality, existentialism and humanism are 'concerned with the integrity of human experience and its personal and social purposes and meaning' (2005: 181). They also have a 'reflexive-therapeutic' purpose, promoting 'human potential and growth' (ibid.).

There are two main ways in which beliefs can be integrated with social work practice. Firstly, clients can be asked about their beliefs as part of a holistic assessment. There has been a significant amount of work invested in designing spiritual assessment techniques and tools (Sherwood, 1998; Hodge, 2003b; Culliford, 2007). Existing spiritual assessment tools include: Stoll's question template (Stoll, 1979); HOPE questions (Anandarajah and Hight, 2001); FICA questions (Puchalski and Romer, 2000); spiritual ecomaps, spiritual genograms, spiritual lifemaps and spiritual histories (Hodge, 2000, 2005a, 2005b). Such tools provide scope for the incorporation of both religious and secular spiritualities. Spiritual assessment tools range in their approach covering, direct methods, indicator-based models, audit-tools, value clarification, indirect methods and acronym-based models (McSherry and Ross, 2002, 2010). Some of these tools have been designed with particular types of healthcare in mind (e.g. palliative) and thus may have limited application in social care/work or

practice in the substance misuse field. While Hodge comes from a social work perspective, his work is grounded in American social work practice.

Following up assessments may involve supporting clients to meet their spiritual or religious goals through providing information or making a referral to relevant organisations or communities. Related to assessment, other approaches include: a cultural competence framework for assessing the significance of religion and belief (Furness and Gilligan, 2010); a 'fellow traveller' model for spiritual care (Holloway and Moss, 2010); and religious literacy for social work (Crisp, 2015). These approaches are based around principles of practice rather than specific techniques.

Secondly, aspects of spiritual/religious philosophy or practice may be integrated with social work practice. Examples of spirituality integrated with social work practice are manifold. They include: spirituality with sports and music; African and Caribbean spiritual perspectives; Eastern meditation; Eastern religious philosophies (Zen Buddhism, Hinduism, Islam) and Gandhian philosophy (Stanworth, 2004; Martin and Martin, 2002; Graham, 2002; Wright and Anderson, 1998; Mikulas, 2002; Keefe, 1996; Claxton, 1986; Young-Eisendrath and Muramoto, 2002; Kumar, 1994).

Integrating spirituality and religion into social work is controversial in Scottish social work. Spirituality and religion may be taboo for some workers (Furness and Gilligan, 2010). This may be related to the secularism of social work training as well as the controversy around religion in Scotland and the UK in general. For some social workers, even for those with religious or spiritual sympathies, such topics may be

perceived as ‘too dangerous, too personal, too embarrassing, too old-fashioned, too uncertain or just too difficult to discuss’ (Furness and Gilligan, 2010: 7). Or as Crompton (1996) puts it, ‘[t]o talk about religion and spirituality is for many people as embarrassing as talking about sex, death and money’ (Crompton, 1996 in Furness and Gilligan, 2010: 8). Payne suggests that social work agencies ‘which perform social control and bureaucratic function’ can obstruct the inclusion of spiritual or religious elements into social work because of concerns that workers will impose their own values which may differ from those of their clients (Payne, 2005: 205). Social workers ought to be aware of their beliefs and values and be conscious of how they might conflict with inclusive practice (Hodge, 2003a, 2003c; Osmo and Landu, 2003). This topic will be explored further in the concluding chapter.

2.3 Recovery

2.3.1 Conceptualising recovery

I have previously stated that the definition of recovery, according to the Scottish Government is, ‘a process through which an individual is enabled to move-on from their problem drug use towards a drug-free life and become an active and contributing member of society (Scottish Government, 2008b: vi). This is a narrow, politicised definition of recovery, biased towards promoting responsible citizenship and ultimately saving the state money (Ashton, 2008).

The concept of substance use recovery that has become popularised in Scottish drug policy, research, treatment and recovery communities has its roots in the language

of Alcoholics Anonymous (AA). Recovery is used frequently in AA's *Big Book* (Alcoholics Anonymous, 2013) (25 times according to Whyte House, 2015). While the etymology of recovery is diverse, it is likely that AA borrowed the usage of the word from health discourse. In the *Big Book*, alcoholism is described as an illness and the Twelve Steps are a programme of recovery. While recovery is not clearly defined in the *Big Book*, it suggests that recovery is the process of being restored to health. In AA, recovery can be achieved only through abstinence. Yet recovery in AA is more than abstaining from alcohol, it is also a programme of personal spiritual transformation and social engagement. This concept of recovery has been popularised and expanded to cover a range of substances through the dissemination of other Twelve Step fellowships (e.g. NA, Cocaine Anonymous (CA)).

Contemporary usage of the term recovery, in relation to problematic substance use, has also been influenced by the development of the concept of recovery in mental health discourse (Best, 2014). While mental health recovery has a broader application than substance use recovery, there are parallels (Bradstreet, 2004; Smith-Merry et al., 2010). One of the earliest and most well respected definitions of mental health recovery came from Anthony (1993):

[Recovery is a] deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993: 15)

This definition of recovery focuses on mental health more broadly, building on the theme of personal transformation. It focuses on developing one's personal cognitive resources with the aim of having a more fulfilling and meaningful life, despite the limitations of mental illness.

In 2008, the same year as the publication of *The Road to Recovery*, *The UK Drug Policy Commission* (UKDPC) brought together practitioners, academics, former drug users and family members to develop a UK vision of recovery. For them, recovery was characterised as a process of,

voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society' (UKDPC, 2008: 6)

The UKDPC's definition is not unlike the Scottish Government's (2008b) definition, with its emphasis on citizenship. It diverges in that it suggests an openness to controlled use of substances and it also gives some credence to the importance of an individual's health and wellbeing.

In 2010, the Scottish Government commissioned *Research for Recovery* (Best et al., 2010) to provide an evidence base for their recovery policy. The report draws on the *Betty Ford Institute Consensus Panel's* (BFICP) (2007) definition of recovery: 'a voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship' (222). Like the Scottish Government's definition, this has a political element in that it promotes responsible citizenship. The BFICP suggests that formerly

drug dependent people who are on substitute prescriptions, 'and are abstinent from alcohol and all other non-prescribed drugs' would meet their definition of 'sobriety' (2007: 224). Similarly, the UKDPC report acknowledges that there may be many routes to recovery, including 'medically-maintained abstinence' (UKDPC, 2008: 6). These reports seem to be suggesting that recovery does not necessarily mean total abstinence or sobriety, but rather, abstinence from the drugs that the government perceives as problematic or outwith their control.

Best et al. (2010) conclude that, based on the 'collective definitional work to date,' recovery from a substance use disorder can be characterised by three core dimensions of change:

- Remission of the substance use disorder;
- Enhancement in global health (physical, emotional, relational, occupational and spiritual);
- Positive community inclusion (25).

These points are drawn from White's (2007) discussion of addiction recovery. White attempts to provide a comprehensive definition of recovery in the following:

Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug (AOD) problems utilize internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life (236).

White proposes that recovery is not just about abstinence; its focus should not just be on the substances, but on related problems. White's definition is more comprehensive in that it takes the focus off the individual, and acknowledges that problematic substance use also impacts on families and communities. Consequently, recovery should also involve those affected by the individual's problematic substance use.

White, as a co-author of *Research for Recovery* (Best et al., 2010), evidently influenced the report. White has been a regular collaborator with the Scottish and UK academic recovery community (White, 2011). He has been the lead academic in the emergence of the recovery movement in America (see White 1996, 1998, 2000, 2004, 2006, 2007, 2008a, 2008b, 2009, 2012; White and Kurtz, 2006; White and Cloud 2008). Understandings of recovery in Scotland and the UK have evidently been influenced by the American recovery movement. Another indication of this influence is the *Edinburgh Alcohol and Drug Partnership's* (EADP) adoption of the principles used by the *US Centre for Substance Abuse Treatment* (CSAT) to define recovery. It states:

There are many pathways to recovery. Recovery is self-directing and empowering; recovery involves a personal recognition of the need for change and transformation; recovery is holistic; recovery has cultural dimensions; recovery exists on a continuum of improved health and wellbeing; recovery emerges from a process of healing and self-redefinition; recovery involves addressing discrimination and transcending shame and stigma; recovery is supported by peers and allies; recovery involves rejoining and rebuilding a life in the community. Recovery is a reality (EADP, 2011: 5).

Much more could be said about this and the other definitions of recovery that I have shared. What they illustrate is that recovery is a complex concept that means different things to different parties. Recovery does not describe a form of treatment or intervention, rather it is a process and an ideal goal. Scottish Government drug policy previously focused on a harm-reduction approach, the aim of which was to protect drug users from harm through supporting controlled drug use (e.g. methadone) and safe injecting (Scottish Advisory Committee on Drug Misuse: Methadone Project Group, 2007). This approach implied that lasting change for problematic drug users was not possible – the best that could be hoped for was controlled use, managed by the state. Recovery brings with it a new positivity that freedom from problematic substance use is possible; that there is life beyond problematic substance use. However, these definitions present an ideal of what recovery should look like for an individual, family or community. Achieving such ideals may be very demanding in practice. Like harm-reduction, recovery can be seen as ideological since it can be utilised to promote certain political aims (e.g. Ashton, 2008; Foucault, 1991). As definitions of recovery vary, so do their ideological, ontological and epistemological characteristics. A definition that highlights citizenship may hold underlying assumptions that people with substance use problems are deviants that need to be reformed to fit into society; one that highlights health suggests that they are sick and need to be made well; while one that highlights social impacts supposes that our society is dysfunctional and needs to be mended. While there may be negative ideas underlying definitions of recovery, it could be said that it is underpinned by an ontology of hope through a belief in the potential of personal

transformation. In my research, I have allowed my participants to define what recovery means for them. This will be discussed in chapter three.

2.3.2 Recovery in Scotland

Since the release of the *Road to Recovery* in 2008, Scotland has seen the emergence of a ‘new’ recovery movement (White, 2011). Yet many of the principles of recovery are rooted in historical ‘recovery’ movements and organisations, those which sought to tackle problematic substance use in society through creating supportive recovery-orientated communities. Most of these social groups had strong religious, spiritual or humanist motivations. Problematic substance use in pre-modern Scotland was largely the remit of Christian churches through various social interventions (Cook, 2006). In the late 19th and early 20th Centuries, the Scottish temperance movement emerged, inspiring various temperance fellowships. Following this tradition, in the 1930s Alcoholics Anonymous (AA) was founded. During the 20th Century, the AA ‘Twelve Step’ model was adapted for a range of substances. In this chapter, I will provide a brief overview of the Scottish temperance movement, the Twelve Step fellowships and the new recovery movement. The first two sections will provide an historical context for the recovery movement and highlight the long-term relationship between beliefs and recovery in Scotland.

2.3.2.1 The Temperance movement

The Scottish Temperance Movement was imported from the temperance movement which emerged in America in the late eighteenth century in response to a growing

culture of drinking and concerns over related social disorder (Cook, 2006; White, 1998). The first American temperance society, founded in New York State in 1808, became the model for numerous subsequent groups. It was defined by, 'a pledge to refrain from drinking distilled spirits, weekly temperance meetings, and a campaign of public education marked by meetings, speeches and publications' (White, 1998: 5). The model was imitated by Christian religious leaders from varying denominations, new meetings were established, and a social movement began to emerge. As the term temperance implies, the initial goal of the movement was to encourage moderate drinking. Between 1825 and 1850 the goal of the movement shifted towards abstinence.

At this time in Scotland, whisky was the favoured substance. From the eighteenth century drinking was an accepted part of social life and 'the ability to drink to capacity was deemed to be a national characteristic, if not a virtue' (King, 1979: 4). There was, however, a growing view among the middle classes that public drunkenness among the industrial working classes was a social ill that needed to be addressed. Temperance societies were 'originally conceived as a means by which the middle classes would reform the vices of the lower orders by precept and example' (Paton, 1977: 121). In 1829 John Dunlop, a lawyer and philanthropist, founded the first temperance society in Glasgow based on American temperance principles. Dunlop was a deeply religious Christian and he saw himself as a moral reformer. He wanted to re-educate the population and change social attitudes towards drink (King, 1979). While there was a mixed response to the early temperance movement, even within

the established church, by the 1840s temperance ideals became commonplace, with the publication of books, pamphlets and government reports which demonised alcohol and associated it with religious, moral and economic decay (Paton, 1977). Many temperance unions, brotherhoods and sisterhoods emerged during the mid-nineteenth century, strongly supported by Christian missions and societies, and the Scottish labour movement (King, 1979). Teetotalism (complete abstinence from alcohol) was growing among the clergy, temperance societies were emerging in the main Church denominations and the Free Church played an important role in the reform of licensing laws (Paton, 1977). In the early 1900s the Scottish churches were also instrumental in the passage of the *Temperance (Scotland) Act, 1913*. The Act allowed people in areas of Scotland to vote on whether alcohol should be permitted or prohibited in their area. Though the Church initially did not take up the temperance cause, after 1918 it was its chief defender (Paton, 1977). The popularity of the temperance movement diminished as new drinking patterns, social habits and secularisation emerged during the 20th Century. However, the temperance movement continued to influence how alcohol was perceived in Scotland.

2.3.2.2 AA and Twelve Step fellowships

While the temperance movement declined in Scotland, a new social movement emerged in the USA that would have a lasting impact on Scotland and the world. Alcoholics Anonymous (AA) was a mutual support group that came into being in 1935 in Akron, Ohio (White, 1998). It was similar in many ways to the total abstinence societies and fraternities of the temperance movement, but AA surpassed all of its

predecessors in influence and longevity. The 1930s in America was a challenging time for the alcoholic and their families. An economic depression followed prohibition in the 1920s, many 'drying out' institutions had closed and hospitals were overcrowded. White proposes that a 'vacuum of need existed that begged to be filled with a source of hope' (White, 1998: 127).

Bill Wilson and Dr Robert Smith, the founders of AA, were both alcoholics who recovered through the support of the *Oxford Group*, a popular spiritual movement of the 1920s and 30s founded by a Lutheran minister. They adopted some of the ideas of the *Oxford Group* as well as being influenced by ideas from psychotherapist Carl Jung and William James' *The Varieties of Religious Experience* (James, 1902; White, 1998; Cook, 2007). AA combined spirituality and the medical theory of allergy to alcohol (Kurtz, 1991). While AA did not strictly promote the disease model of alcoholism, it soon became popularised within and associated with AA (Miller and Kurtz, 1994). This theoretical shift towards the medicalisation of alcoholism marked a shift in moral attitudes towards problem drinking. Drinking too much alcohol was no longer a sin, it was the symptom of a medical condition that was beyond an individual's ability to choose.

AA first came to Europe through Ireland in 1946, to England in 1947 and then to Scotland in 1948 (Butler and Jordon, 2007; Alcoholics Anonymous, 2013; Silkworth, 2012a). There are approximately 4400 group meetings each week in Great Britain and an estimated global membership of 2,000,000 in 150 countries (Alcoholics

Anonymous, 2013). Spirituality is central to AA's programme. The Twelve Steps of AA, which are the core principles of the programme, utilise the concepts of higher power and spiritual awakening. This is clear from the language of the Steps, they include the phrases: 'a power greater than ourselves'; 'God as we understand him'; 'sought through prayer and meditation to improve our conscious contact with God'; and 'having had a spiritual awakening' (Alcoholics Anonymous, 2013; see the Twelve Steps in appendix 12.7).

The AA organisation tries to avoid any formal association with religious institutions or denominations. AA's 10th tradition explicitly states that members should not express opinions on any religious controversies, promoting a spirituality for people of 'all faiths or none' (Alcoholics Anonymous, 2013; Cook, 2007: 142). Having said this, the AA *Big Book Online* (Alcoholics Anonymous, 2013) devotes an appendix to 'The Religious Views on AA'. They state that '[c]lergymen of practically every denomination have given AA their blessing', and they include some quotes from Christian clergy. The following are excerpts from Roman Catholic and Episcopal sources:

There is something spiritual about AA . . . and Catholic participation in it almost invariably results in poor Catholics becoming better Catholics.

The basis of the technique of Alcoholics Anonymous is the truly Christian principle that a man cannot help himself except by helping others. The AA plan is described by the members themselves as 'self-insurance.' This self-insurance has resulted in the restoration of physical, mental and spiritual health and self-respect to hundreds

of men and women who would be hopelessly down and out without its unique but effective therapy (Alcoholics Anonymous, 2013).

So in one sense AA is spiritual but not religious, yet in another, it is eager to gain the approval of religious institutions. AA is clearly rooted in Western Christianity but in non-Western cultures fellowships have been skilful in adopting the spirituality of their cultural context. Muslims and Jews, for example, have been able to integrate their own understanding of God and spirituality into the AA model. The non-religious spirituality of the programme has also enabled some atheists and agnostics to partake in the programme. This has led to the global growth of AA, serving the needs of people from diverse of religious and non-religious backgrounds (Silkworth, 2012b).

AA's organisational model has also spread through sister fellowships which seek to provide support for men and women who have problems with drugs other than alcohol. The first of these was Narcotics Anonymous (NA), founded in the 1940s (White, Budnick, and Pickard, 2011). Since then a multitude of fellowships, patterned on AA, have emerged to deal with a range of substances (as well as behavioural addictions). These include: Cocaine Anonymous (CA); Heroin Anonymous; Marijuana Anonymous; and Crystal Meth Anonymous, to name a few. AA, NA and CA are the most popular of the 12 step groups in Scotland. In addition, the Twelve Steps have been re-interpreted by religious groups who have formed more explicitly religious support groups (e.g. Celebrate Recovery; for list see Wikipedia, 2012). The Twelve Step approach has also become popularised through being utilised in treatment settings as part of group therapy. This was originally developed as the Minnesota

Model, through which came Twelve Step Facilitation Therapy (Winters et al., 2000). Scotland is also home to a number of treatment centres that use the 12-steps (e.g. LEAP, Castle Craig, Alexander Clinic) or that have implicit or explicit religious or spiritual programmes (e.g. Rainbow House, Bethany Christian Centre, Teen Challenge Whitchester House).

2.3.2.3 The new recovery movement

The success of the *Scottish Recovery Network* (launched in 2004), which deals with mental health recovery more broadly, helped to pave the way for the *Road to Recovery* in 2008 (Best et al. 2010). Since 2008 Scotland has seen the emergence of a 'new' recovery movement which seems to have been imported from the USA (White, 2011). The movement is evident from the emergence and steady growth of a number of Scottish-based recovery orientated organisations and groups. These included the *Scottish Recovery Network* (for mental health), the *Scottish Recovery Consortium*, the *Serenity Café*, *North East Recovery Community Glasgow* (NERC) and *SMART Recovery*. The NHS Scotland has also piloted a recovery orientated rehabilitation centre, *Lothian and Edinburgh Abstinence Project* (LEAP), with much apparent success (Figure 8, 2010). Edinburgh and Glasgow have also pioneered recovery hubs which bring together drug and alcohol services provided by the NHS, local authority and voluntary sector services.

2.3.3 Recovery and beliefs - evidence and theory

In this chapter I will discuss the evidence-base for recovery in general; the theory of recovery pathways; and the evidence-base for recovery in relation to religion, spirituality; and in relation to secular beliefs. The scope of the thesis will allow only an overview of the evidence-base, rather than an in-depth critical analysis of the studies mentioned.

2.3.3.1 Evidence for recovery

It has been suggested that there are multiple pathways to long-term recovery, however, little is known about the nature of recovery from a scientific standpoint (White and Kurtz, 2006). The evidence-base for recovery has four main limitations: UK based research about recovery is sparse; other evidence is dated; much of it is focused on alcohol rather than illicit drugs; and most of the evidence is from the USA (Best et al., 2010: 8). Groshkova and Best (2011) offer an overview of the evidence-base for substance misuse recovery in the UK. The evidence comes from three main sources: longitudinal cohort studies, natural recovery, and treatment outcomes. They also discuss studies which attempt to measure recovery processes, developmental models of change, recovery capital and mechanisms of long-term change.

There have been only a few relevant longitudinal studies conducted in the UK. One such study was conducted by Edwards et al. (1977, 1986, 1987, 1988), studying men with alcohol problems referred to the Maudsley outpatient clinic. At the 10-year point 'a substantial proportion of individuals had managed to stably move away from

dependent drinking' (Groshkova and Best, 2011: 22), with five years appearing to be a key marker for stable recovery.

Groshkova and Best (2011) also highlight two longitudinal studies by Vaillant (1973, 1983) conducted in the USA. Firstly, in a study of male 'addicts' who left Lexington Hospital, New York, in the mid-50s, he found that 22% were abstinent after 5-year and 37% were abstinent after 10 (Vaillant, 1973). A second study followed 400 school boys, from the ages 14-47, 110 of whom were thought to have developed alcohol dependence, 49 of whom became abstinent for a year or more (Vaillant, 1983). Three key factors were identified as to have predicted abstinence.

(1) finding a substitute dependency to compete with alcohol use (e.g., meditation); (2) obtaining new social supports (e.g., a grateful employer or a new marriage); and (3) inspirational group membership (e.g., discovering a sustained source of hope, inspiration, and self-esteem in fundamentalist religion or AA) (Groshkova and Best, 2011: 22).

Natural recovery refers to the process of recovering without treatment. Some studies of natural recovery suggest that the number of those who recover without treatment may be equal to or greater than those who do (Waldorf and Biernacki, 1979; Stall and Biernacki, 1986). One of the earliest such studies by Winick (1962) introduced the idea of 'maturing out'. Winick studied the official records of 'addicts' in files of the *Federal Bureau of Narcotics*. He noticed that that as addicts approach the ages 35 to 40 they disappeared from records. He inferred that this meant that they experienced some kind of transformational life processes similar to how adolescents can mature out of juvenile delinquency. Winick's theory is well known in addiction literature but

he provided little suggestion of how maturing out might happen (McIntosh and McKeganey, 2002). Despite this, further studies have supported the maturing out concept (Waldorf, 1983; Biernacki, 1986; Prins, 1994). Waldorf (1983) theorised five possible routes within the maturing out thesis:

- individuals can 'drift' out of addiction;
- become alcoholic or mentally ill;
- give up due to religious or political conversion;
- 'retire' by giving up the drug while still retaining some aspects of the lifestyle;
- or change because their situation or environment has changed (McIntosh and McKeganey, 2002: 3).

One pertinent study which examined the typology of natural recovery was conducted by Klingemann (1991). In a qualitative study, based in Switzerland in 1988 and 1989, Klingemann telephone interviewed 30 former alcohol-dependent users and 30 former heroin-dependent users, with minimal or no treatment experience. He identified a typology of motivation to stop characterizing three main processes of what he calls 'autoremission'. The first process that Klingemann identifies is 'hitting bottom', a phrase taken from AA. In this scenario, the negative consequences of addiction lead the user to the point of '[p]hysical, interactional and psychological collapse' (Denzin in Klingemann, 1991: 733). Klingemann draws on Ludwig to illustrate this condition:

[V]irtually all respondents . . . arrived at a common cognitive destination: mental associations to alcohol with very unpleasant, sickening, humiliating or distasteful experiences of a personal nature (Ludwig in Klingemann, 1991: 733).

Within the research group, Klingemann identifies two sub-groups: 'cross-road types,' who chose to drop out in response to negative circumstances, before reaching 'the subjective absolute low point' and 'pressure-sensitive types,' who react to social pressure (Klingemann, 1991: 734). Klingemann argues that hitting rock bottom cannot be empirically supported in all cases. The second process of autoremission he proposes is comparable to maturing out, involving gradual change over time, motivated by positive changes in their social environment and 'pursuing new aims in life and conversions in the broadest sense' (735). The third process were esoteric or religious experiences which could be seemingly isolated revelations or linked to community influences.

Groshkova and Best (2011) also consider treatment outcome studies. They focus on the findings from three key studies: Simpson and Sells (1990); The English *National Treatment Outcome Research Study* (NTORS; Gossop, Marsden, & Stewart, 1998; Gossop et al., 2002) (and the follow up, *Drug Treatment Outcomes Research Study* (DTORS; Jones et al., 2009); and the *Scottish Drug Treatment Outcome Research Study* (DORIS; McKeganey et al. 2006). They state that evidence for positive outcomes for 'intensive, abstinence-based interventions is reasonably encouraging' (24). However, the focus of these studies was relatively short-term (up to 33 months, with the exception of NTORS which had a 5 year follow up) and can say little about processes of long-term recovery. Groshkova and Best (2011) suggest that studies which use the 'life-course perspective model' and include the analysis of recovery trajectories and turning points should be the way forward for studying recovery (e.g. Hser et al.,

2007). Some of the key recovery processes and factors that Groshkova and Best (2011) highlighted were:

- Supportive social resources such as job, family and emotional support
- Restoring a spoiled identity
- Broader social environment
- Stigma and labelling
- Interpersonal and life and coping skills

The concept of recovery capital is also central to popular understandings of recovery (Cloud and Granfield, 2001; Granfield and Cloud, 2001; Laudet and White, 2008; Best and Laudet, 2010; Skogens and von Greiff, 2014). The concept was coined by Granfield and Cloud (1999). It is the range of internal and external resources that can be accessed to initiate and sustain recovery from substance problems. The concept is rooted in Bourdieu's (1980) concept of social capital. Types of recovery capital have been variously categorised as: personal, family/social and community cultural (White and Cloud, 2008); and social, physical, human and cultural (Cloud and Granfield, 2008). Many studies have focused on the benefit of social capital in particular (e.g. Whitley and McKenzie, 2005; Best, Ghufra, et al., 2008). This research has been used for the justification of promoting recovery-orientated communities, utilising peer-support workers (Best and Laudet, 2010; Best, 2014).

Some of the key conclusions of *Research for Recovery* (Best et al., 2010), based on a survey of the available evidence are:

- 'Sustained recovery is the norm, although the time to recover and the pathways involved are highly individualistic'.

- 'The best predictor of the likelihood of sustained recovery is the extent of 'recovery capital''.
- 'Barriers to recovery include psychological problems (mental illnesses and the absence of strengths, such as self-esteem), significant physical morbidities (including blood borne viruses), social isolation and on-going chaotic substance use'.
- Structured treatment is only part of the support that most people will need to recover. 'Ongoing support in the community is essential for maintaining and continuing the recovery journey'.
- 'Recovery is not just about the individual, but significantly it also involves – and impacts upon – families and communities'.
- 'Switching to a recovery model is likely to require a fundamental change in culture and attitudes by many professionals and by communities' (Social Research, 2010: 2).

2.3.3.2 The pathways theory

Research for Recovery (Best et al., 2010) draws heavily on the concept of pathways to recovery (the word pathways is used 27 times in the text, excluding references). Best et al., drawing on White and Kurtz (2006), suggest that there are diverse pathways and personal styles of recovery. Pathways of long-term recovery span 'secular, spiritual and religious frameworks of personal transformation,' they 'constitute broad organising/sense-making frameworks for change' (2010: 25, 27). Best et al. argue that treatment philosophies ought to 'embrace' the diverse pathways of recovery – secular, spiritual and religious (42). The language of pathways is not new in drug research (e.g. Biernacki, 1986; Humphreys et al., 1995; Laudet et al., 2002), but the particular version of pathways used in *Research for Recovery* comes from its co-author, William White.

White first used the term pathways in *Pathways from the culture of addiction to the culture of recovery* (White, 1986), developing the concept more fully with Ernest Kurtz (White and Kurtz, 2006). Pathways of recovery, according to White and Kurtz, 'refers to the different routes of recovery initiation' (2006: 15). They identify the origin of the idea of pathways in a term used by the founder of AA, Bill Wilson, who purportedly said, "The roads to recovery are many". They expand the term to, *cultural pathways to recovery*, meaning the prescribed avenues of recovery defined by specific cultures or subcultures. These pathways, they suggest, could be products of developmental, medical, religious or political consciousness (White and Kurtz, 2006). Styles of recovery exist within particular pathways, depicting 'variations in beliefs and recovery support rituals' (16). To illustrate, they suggest that Twelve Step programs are one of the common pathways of recovery, and each individual takes an idiosyncratic approach to how they "work the program" – this is their style of recovery.

White and Kurtz (2006) also suggest that individuals adopt different *recovery initiation frameworks* in their pathway to recovery. Frameworks can be secular, religious or spiritual. In religious, or faith-based frameworks, recovery happens 'within the rubric of religious experience, religious beliefs, prescriptions for daily living, rituals of worship and the support of a community of shared faith' (23). Recovery in a religious framework is often seen as a by-product of religious conversion or affiliation and 'the reconstruction of a faith-based personal identity or

lifestyle' (23). Recovery is viewed as a gift from God, and religion is both a catalyst and sustaining force (White and Whithers, 2005).

Spiritual frameworks of recovery, according to White and Kurtz, overlap and often coexist with religious frameworks. They understand spirituality to 'involve experience of connection with resources within and beyond the self, and involve a core set of values (e.g. humility, gratitude, and forgiveness)' (White and Kurtz, 2006: 24). Alcoholics Anonymous is an example of a spiritual framework since it addresses defects of character, promotes self-investigation and encourages one to look beyond oneself.

A secular framework is non-religious and non-spiritual. Secular recovery 'rests on the belief in the ability of each individual to rationally direct his or her own self-change process' (White and Kurtz, 2006: 24). Secular frameworks involve self-assertion and the use of rational knowledge (White and Nicolaus, 2005). Despite the critical difference in each type of framework, each type share, a re-visioning of self, a re-visioning of one's life-context and restructuring of life-stance and lifestyle (2006:25). White and Kurtz (2006) propose that Twelve Step fellowships, whether explicitly spiritual or secular, are recovery frameworks. Different frameworks can be utilized exclusively, concurrently or sequentially. One framework can be used to initiate recovery and another can 'maintain and enrich that recovery over time' (33).

The concept of pathways has been utilised and adapted in further research by White and others (White, 2016; Yates and Malloch, 2010; Best et al., 2011). Recovery

pathways and frameworks have not been developed conceptually beyond White and Kurtz's basic explanations (2006). The following is a summary of the key concepts based on White and Kurtz (2006) and Best et al. (2010):

- Recovery pathways constitute the diversity of routes of recovery initiation
- Pathways can be associated with specific recovery cultures or subcultures
- Pathways are defined by secular, spiritual and religious frameworks
- Frameworks organise and make sense of the recovery experience
- Pathways are further delineated by styles of recovery which are variations in belief and ritual

In a personal correspondence with William White in 2013, he clarified the meaning of recovery frameworks to me:

I usually use the terms frameworks and pathways to convey broad organizing schema for recovery, e.g., religious, spiritual, secular; treatment-assisted, peer-assisted, natural recovery; medication-assisted recovery. These involve "structures of belief" that help one re-construct a recovery-enhancing personal story and lifestyle: what I was like before addiction, how I came to be addicted and its consequences, what happened to spark and sustain change, and my life in recovery. The elements of that story do not always have to be factually true but they must be metaphorically true in the sense that they serve as catalysts of personal transformation. They also of course evolve over time. I tend to use the term "styles of recovery" to convey variations in recovery maintenance practices within particular frameworks/pathways of recovery.

The metaphor of pathways seems to be an appropriate one for describing the often circuitous journeys that individuals travel, from their first use of a substance, through to problematic use, to numerous relapses and on to recovery (DiClemente and

Prochaska, 1998). White and Kurtz's explanation of secular, spiritual and religious frameworks lacks depth and clarity. The beliefs and rituals that they associate with a religious framework are perhaps better suited to Abrahamic religions than other forms of religious tradition (White and Kurtz, 2006: 23). Their definition of spirituality is similarly narrow, conforming to the spirituality of Alcoholics Anonymous. Their understanding of frameworks perhaps fit in majority American culture, but it is questionable whether they would make sense in other cultural contexts.

2.3.3.3 Recovery, religion and spirituality

There are significant numbers of research reports and systematic reviews that explore the relationship between religion, spirituality and problematic substance use (Cook, 2004; e.g. Laudet et al., 2006; Galanter, 2007; White, 2008b). Geppert et al. (2007) produced a bibliography of research studies which examined religion, spirituality and substance addictions. The studies reviewed came primarily from the disciplines of medicine, pharmacology and psychology but anthropology, sociology and religious studies were also represented. Only six of the studies came from the social work discipline. Although Geppert et al. (2007) was not a formal systematic review, it reviewed the articles on the basis of their abstracts. They observed consistent 'inverse relationships between religiousness or spiritual practices and substance use', concluding that, the 'widespread belief that spirituality is important in recovery is consistent with findings to date' (394). They suggested that more research is needed to understand how 'spiritual processes or interventions may help to alleviate addiction and related suffering' (ibid.).

Assessing the validity of studies which examine religion, spirituality and substances is challenging. The majority of academics who have chosen to study problematic substance use come from disciplines which are rooted in a positivist epistemology (Bondi, 2005). The academic field of 'addiction' studies is dominated by medical doctors, psychologists, neurobiologists and pharmacologists. While it would be unrepresentative to say that all academics from these disciplines ascribe to a positivist epistemology, their traditions suggest that their concern is with empirical observation and measurement. This raises problems when firstly, thinking about substance use. While understanding the effects of drugs on the body and brain chemistry may be important, it would be negligent to ignore the social and cultural aspects of substance use, the nuances of which are difficult to portray within a positivist framework.

Secondly, religious or spiritual belief and the impact it has on a person is very difficult to observe or measure. While it may be possible to measure how often someone attends a service of worship, or how often they meditate, making clear links between such practices and life changes is difficult when considering the complexity of personal characteristics and resources. There is also the difficulty of how religion or spirituality should be defined. Spirituality in particular has proved difficult to define, as Miller (1998: 980) proposes, spirituality 'is very difficult to delimit. By its focus on the transcendent, it defies customary conceptual boundaries'. Despite the challenges of researching religion and spirituality, I will now provide an overview of what the

research findings suggest about the relevance of beliefs to recovery, first in relation to religion and spirituality, and then to secular beliefs.

As I have already discussed, there is a blurring between the boundaries of the concepts of religion and spirituality. Because of this, much of the literature that concerns religion and recovery also concerns spirituality and recovery. There is a significant body of research that seeks to address both religion and spirituality in term of their relevance to health in general (e.g. Koenig et al., 2012; Koenig, 2012) and to mental health more specifically (Miller and Thoresen, 2003; Koenig, 2009; Cook et al., 2009; Gilbert, 2011), both of which have some relevance to problematic substance use. Koenig (2009) offers a recent review of the literature on religion, spirituality and mental health. His review has limitations in that it was selective, not systematic, and he did not address studies that were not statistically significant. Koenig found that ‘religious beliefs and practices may be important resources for coping with illness’ (Koenig, 2009: 283). For example, those who were more religious had lower rates of depression and there appeared to be fewer suicides or more negative attitudes toward suicide among the more religious. While overall it seemed that religious or spiritual belief and practices had a positive effect, there were several studies which indicated that they could contribute to mental pathology, as Koenig sums up in the following quote:

. . . especially in the emotionally vulnerable, religious beliefs and doctrines may reinforce neurotic tendencies, enhance fears or guilt, and restrict life rather than enhance it. In such cases, religious

beliefs may be used in primitive and defensive ways to avoid making necessary life changes (Koenig, 2009: 289).

Koenig et al (2012) reviewed 138 studies that explored religion and substance abuse (pre-2000), 90% of which found significantly less substance use and abuse among the more religious. However, among other potential limitations, most of the studies were carried out in high schools or college, suggesting that participants did not exhibit severe problematic substance use. Cook (2009), taking a psychiatry perspective, looked at the research on spirituality and substance misuse. He highlights a number of studies that indicate that religious behaviour or affiliations can be a protective factor against problematic substance use and is associated with various measures of mental well-being (Chamberlain and Hall, 2000; Koenig, 2005). He suggests that this association may be due to the installation of moral values in religious community or 'a function of conforming to the norms of a social group in which substance use or misuse is less acceptable' (Cook, 2009: 143). Cook also highlights a number of studies which focus on spirituality more generally and suggest that it can also be a protective factor (Zimmerman and Maton, 1992; Stewart, 2001; Ritt-Olson et al., 2004; Leigh et al., 2005).

Humphreys and Gifford (2006), in their survey of religion, spirituality and substance misuse, select only three treatment outcome studies that meet their criteria for good methodology (longitudinal, comparison groups, high follow up-rates and reliable/valid measures). The first, Moos et al. (1978), examined 97 men in a residential Salvation Army (SA) treatment programme for alcoholics. This treatment

was compared with a half-way house and hospital-based programme. Those who engaged with the SA programme had significantly better outcomes than the other treatment groups. The spiritual elements of the programme included attendance of AA meeting and Christian counselling and worship. It also included therapy groups, community meetings, educational input, vocational rehabilitation and recreational activities. However, assessing the value and impact of spiritual elements in the programme is problematic. The spiritual elements are not easily isolated from the other elements of the programme. In addition, comparing three very different types of treatment results in complex data that it is not easy to interpret.

The second study highlighted by Humphreys and Gifford (2006) is Project MATCH (Project MATCH Research Group, 1997). MATCH compared the efficacy of three treatment approaches: Twelve Step facilitation therapy (TSF), cognitive behavioural therapy (CBT) and motivational enhancement therapy (MET). The findings showed that after three years 30% of the former alcoholics had not drunk during the previous 3 months (Ashton, 1999). TSF constituted the spiritual treatment in that it involved attendance of AA and working the Twelve Step. The results indicated little difference in the effectiveness of the treatment approaches. If anything, TSF showed slight disadvantages compared to CBT and MET. It has been suggested that it is the therapeutic alliance which was the effective element of all the treatments (Aston, 1999).

The third highlighted study was by Humphrey and Moos (2001). They studied 1774 substance dependent veterans who were treated in in-patient programmes with either a Twelve Step or cognitive-behavioural orientation. Those involved in the Twelve Step programme had higher levels of participation (39% compared to 4%). Patients using the Twelve Step programme exhibited higher rates of abstinence after 1 year (46% vs 36%). The fact that those in the cognitive-behavioural group had much less programme time creates a problem for comparing the approaches. As in the other studies, isolating the spiritual element of treatment proves problematic. The three studies exemplified by Humphrey and Moos (2001) also say little about the implication of drug type on spirituality and recovery.

Chitwood et al. (2008) conducted a systematic review of the literature on religiosity and substance use. They identified 105 empirical articles published between 1997 and 2006 related to the topic. Within these, they identified eight dimensions of religiosity. These were:

- Organisational religiosity
- Religious affiliation
- Subjective religiosity
- Religious belief
- Nonorganisational religiosity
- Religious coping
- Spirituality
- Multidimensional religiosity (Chitwood et al., 2008: 665-666)

The majority of studies focused on the first four of these dimensions. They also identified the percentage of studies that looked at particular drug types: alcohol

(81%), Marijuana (36.2%), cocaine/crack (13.3%), opiates (4.8%), other illicit drugs (7.6%), drug in general (30.6%) (ibid: 668). This illustrates that the majority of studies have looked at alcohol and neglected most other types of drug. Overall, Chitwood et al. (2008) found that, '[h]igher levels of religiosity and spirituality . . . for the most part have been found to be associated with decreased risk of substance use'. This general conclusion is supported by other reviews (Geppert et al, 2007; Cook, 2009; Koenig et al., 2012; Lucchetti and Lucchetti 2014). However, Chitwood et al (2008) note that the research is complicated due to the different ways that religion and spirituality is defined. They also point out that the majority of the research focuses on alcohol among adolescent and college populations (also noted by Koenig et al., 2012).

It should be noted that while most of the literature points towards the benefits of religion and spirituality in protecting against problematic substance use or facilitating recovery, some studies conclude the contrary. Chitwood et al (2008) identify four that suggested religiosity was associated with increased risk of use or misuse: Staton et al. (2003) and Sussman et al. (2006), concerning measures of spirituality; Assanangkornchai et al. (2002), concerning organisational religiosity; and Marsiglia et al. (2005), concerning religious affiliation.

The majority of studies that I have referred to were conducted in the USA. This brings into question the validity of this research when applied to the Scottish context. Not only are drug-using cultures relatively different between the USA and Scotland, but

cultural perspectives and practices of religion and spirituality are significantly different (Wuthnow, 1998; Putnam and Campbell, 2010). For example, around 56% of Scotland's population affiliate themselves with a religious belief, while in the USA, about 83% report religious affiliation (National Records for Scotland, 2013; Pew Research Center, 2012). Religion is certainly important to over half the people in Scotland but in terms of its religious identity it is a 'nation divided' (Barna, 2015).

There are very few studies which consider beliefs and problematic substance use in Scotland. *The Road to Recovery* (Scottish Government, 2008b) does not mention religion or spirituality. *Research for Recovery* (Best et al., 2010) mentions spirituality nine times, all cases of which come from American-based research. *Melting the Iceberg* (Matthews, 2010) suggested that there may be a need to look at spirituality and faith further in the Scottish context:

Staff working within drug treatment services face many challenges in attempting to realise the goals set out in The Road to Recovery. Perhaps the greatest of these challenges is to foster empowerment and engage with areas not often discussed previously. For example, discussions of spirituality and faith - not necessarily based upon a theocratic view (i.e. religious), but faith and spirituality in the wider senses (19)

A few studies make specific reference to religion and problematic substance use in the Scottish context (Kreitman, 1972; Gillies, 1976; Anderson and Plant, 1996) but only two address these topics directly (Mullen et al. 1986; Engs and Mullen, 1999). Engs and Mullen (1999) looked at the effect of religion and religiosity on drug use among students. They took their sample from students (3117 females, 949 males) in

'helping profession' departments, in 22 universities and colleges, in five Scottish cities. Their questionnaire data suggested that students' religious affiliation and strength of religious belief impacted how they used, or did not use, licit and illicit drugs. They concluded that, irrespective of gender, 'those who were not religious were more likely to consume both licit and illicit drugs,' as were those who defined their religion as 'other' or had no religious preference. Also those who were Roman Catholic were more likely to use substances than Protestant believers. The study did not address why these results occurred. There may be issues with the reliability of this data as it is based on self-perceptions of drug use and religious sensibilities may have also affected how participants disclosed their drug use.

In another study, Engs et al. (1990) compared the influence of religion and culture on drinking behaviour between the USA and Canada. They found that, 'American Roman Catholic and mainstream Protestant students consume more alcohol and have more alcohol abuse problem compared to Canadian students within the same religious group'. Comparing these studies illustrates the complexity of relationship between religion and substance use and also suggests that cultural contexts play an important part in how societies interact with substance. This point also came out in Mullen et al. (1986):

[I]t is only when . . . more pervasive cultural influences are taken into account that the complex relationships between religion and attitudes towards alcohol can be fully understood.

To understand Scottish society's relationship with substances, Scottish culture must be taken into account (Mills, 1959). There is therefore a need for Scottish-based research to understand the relationship between problematic substance use and spirituality and religion in the Scottish context. Scotland has a unique culture which needs to be examined to understand the dynamics between religion, spirituality and substance use in Scotland.

While there is no Scottish-based research that looks directly at issues of spirituality and recovery from problematic substance use, there has been one study conducted around recovery from mental health problems that discusses the roles of religion and spirituality. While mental health recovery is broader than substance misuse recovery there are parallels (Bradstreet, 2004; Smith-Merry et al., 2010). The study (Brown and Kandirikirira, 2008) was based on the narrative accounts of 64 people around Scotland, from rural and urban locations. The report highlighted a number of issues around religion and spirituality. For a *few* participants, spirituality 'played a key role' and 'a spiritual approach to life helped them manage symptoms better', additionally religious beliefs were 'a catalyst to recovery journeys for *some* narrators' (Brown and Kandirikirira 2008: 36, 37; emphasis added). The study seems to indicate that only a minority of individuals found religion and spirituality to be helpful in the recovery process. In contrast, a prominent American study which focused on recovery from problematic substance use said that, '*many* report that a spiritual or religious connection to the transcendent is part of their recovery' (Laudet et al., 2006; emphasis added). As discussed above, the American literature seems to suggest that

religion and spirituality are important aspects of recovery for many in American society. In the case of Brown and Kandirikirira (2008), it is unclear why there was only a minority who found religion and spirituality helpful. It could say something about Scottish culture, how the research was conducted or the difference between mental health recovery and substance misuse recovery.

Overall, Brown and Kandirikirira (2008) identified that religion and spirituality were helpful resources for recovery, in terms of a positive self-identity, re-framing, providing company, and providing focus, optimism/hope, meaning and purpose. However, they found that for some individuals, religious beliefs could play a negative role. For one person the idea that their illness was punishment from God played on their conscience. While much of the literature highlights the helpfulness of religion and spirituality in the process of recovery, it is important to acknowledge the obstructive or regressive role they can play for some. This is a theme also identified by Holloway and Moss (2010). They note that religion and spirituality can be, 'creative, generous and awesome', or 'destructive, oppressive and awful' (36).

2.3.3.4 Recovery and secular beliefs

It could be argued that the majority of research conducted in addiction treatment and recovery is based on a secular belief system, that of the empirical, scientific paradigm. The large body of work that looks at Twelve Step approaches provides a counter-point in its consideration of spirituality. Treatment providers and communities of recovery commonly marry so called scientific approaches with the

Twelve Step approach. Some people seeking recovery have struggled to come to terms with the spirituality or perceived religiosity of Twelve Step approaches and additionally, some professionals have found it to be incongruent with their outlook. As a result, alternative 'secular' approaches to recovery have been developed.

Lemanski (2000), writing in *The Humanist*, is sceptical of the Twelve Step approach and believes that it is un-scientific. He provides a summary of some of the American recovery organisations that have taken a secular approach since the mid-70s. These include *Women/Men for Sobriety*, *Secular Organizations for Sobriety* and *Rational Recovery Systems*. White and Nicolaus (2005) provide a more detailed overview of the development of secular recovery groups and styles. They note that most of these groups are rooted in the psychology of Carl Rogers (1902 – 1987; founder of the humanistic approach/person-centred therapy; Rogers, 1951) and Albert Ellis (1913 – 2007; founder of rational emotive behaviour therapy (REBT) which influenced the development of cognitive behavioural therapies (CBT); Dobson, 2010). According to White and Nicolaus (2005), while the Twelve Step approach relies on surrender to a higher power to find recovery from addiction, the secular approach posits a power of 'irrepressible resilience – within the self that seeks freedom from the drug and pushes the addicted person towards recovery and a meaningful life' (3).

The most influential secular recovery approach in Scotland has been SMART (Self-Management and Recovery Training) recovery. SMART claims to be science-based, drawing on the theories of REBT, CBT and motivational enhancement techniques

(Horvath and Yeterian, 2012). Evidence for the effectiveness of SMART recovery is still minimal. There is some evidence for the use of CBT in treating problematic substance use (McHugh, et al., 2010), but none for REBT. Horvath and Yeterian (2012) discuss a few relevant studies which suggest that: participation in SMART (or another mutual-help group) positively affected the duration of continuous abstinence; SMART was more effective than a Twelve Step based treatment at improving participant's employment status and medical concerns (but less effective at reducing alcohol use); participants attending a UK based group reported that SMART was more useful than other recovery groups they had attended because, 'the emphasis on moving forward, the nonhierarchical nature of groups, and the shared experiences of group members' (144).

2.3.4 Social work and recovery

In a review of the evidence concerning social work services and recovery from substance misuse Galvani and Forrester (2011a) make a number of key observations:

- Social workers 'are well placed to play an active role in supporting people with alcohol and other drug problems because of social work's holistic and ecological approach' (41).
- There was 'clear and consistent evidence that social work and social care can make an important and positive contribution to increasing the effectiveness of substance use treatment services' (48).
- Social work services 'were often successfully used with people with substance use problems and what are often

considered to be challenging additional circumstances, such as those with a mental illness, those who are homeless or those using alcohol and/or other drugs during pregnancy' (48, 49).

- A case management approach is effective with individuals with complex needs providing the form of case management is matched with the needs of the service user. For more severe cases this will mean more intensive and long-term engagement (6).
- '[D]eveloping and sustaining a relationship appeared more likely to be linked to positive outcomes than forms of case management which focussed on effective service coordination' (6).

Support for many of these ideas is repeated by Galvani in *Supporting People with Alcohol and Drug Problems* (2012). She clarifies the importance of social work's ecological theoretical framework in supporting people with substance misuse problems. An ecological perspective takes into account, not just the individual, but how the individual interacts with her or his social environment. It has been argued that addressing the social aspects of problematic substance use and building 'social capital' is essential to recovery (Granfield and Cloud, 2001; Whitley and McKenzie, 2005).

Galvani (2012) notes that while the *National Occupational Standards* for social work states that social workers should learn 'theories, models and methods' for working with drug and alcohol users, it does not stress the need for social workers to 'have an underpinning knowledge of the subject and confidence in recognizing and identifying issues before being able to apply theories, models and methods' (Galvani, 2012: 7).

Research by Galvani and Forrester (2011b), and Galvani et al. (2011) shows that many social workers lack the training and confidence to deal with substance use problems.

The Scottish Government has gradually acknowledged the need to train social workers to deal with substance use problems (Scottish Executive, 2003; 2005; Scottish Government, 2010b) Galvani and Forester (2011a) reported that ‘formal academic-based’ social work education has failed to prepare social workers for the task of working with substance misuse issues (33), yet social workers ‘are well placed to play an active role in supporting people with alcohol and other drug problems because of social work’s holistic and ecological approach’ (41). Their review found that there was ‘clear and consistent’ evidence suggesting that social work services ‘can make an important and positive contribution to increasing the effectiveness of substance use treatment services’ (48). There appeared to be particular success with people with complex needs including mental illness, homelessness or women using substances when pregnant (49).

Some social workers, mainly in the USA, have also sought to approach recovery by integrating religion and spirituality (e.g. Greene et al., 2003; Bliss, 2007; Carlson and Larkin, 2009; Bradley, 2011). Suggested approaches are not dissimilar to those in my discussion of social work and beliefs (Ch. 2.2.5). They include conducting *Spiritual-Religious Lifestyle Profiles* (Hodge et al., 2007); introducing Eastern spiritual teaching and practices (Kissman and Maurer, 2002); utilising Charismatic/Pentecostal

Christian 'revival' (Belcher and Burry, 2007); and focusing on the assessment and integration of clients' spiritual beliefs into treatment (Diaz et al. 2011).

3 Research Design and Methodology

The primary research question that has guided this thesis has been: what role do beliefs play in individuals' experiences of recovery? Four other questions have emerged as my research has evolved:

- How do individuals construct beliefs in recovery?
- How do individuals practise beliefs in recovery?
- How do individuals integrate beliefs in recovery?
- What are the implications for social work practice?

In this chapter I will discuss *how* I have tried to answer these questions, and *why* I have made decisions about my research design and methods. In summary, my method consisted of twenty semi-structured interviews with individuals in recovery. My method was influenced by narrative theory and in my analysis I drew on constructionism, adapting thematic narrative analysis. In the following, I will elaborate my theory and method by discussing: reflexivity; my philosophical assumptions and theoretical approach; sampling and recruitment; data collection; analysis; ethics; and quality and limitations.

3.1 Reflexivity

In the introduction to this project I provided some background information about myself and how I developed an interest the topic for this PhD. I did this, not only to provide some interesting background information for the reader, but all also to give some insight into my perspective as part of reflexive authorship. In this section I will

firstly explore what reflexivity means in the academic literature. Secondly, I will write more about my personal and social identity and how this might have impacted my data. I use the following headings to reflect upon my identity and its potential impact on my research: personal belief system, attitude to substance use; educational and professional background.

Reflexivity – the theory

Reflexive thought assumes that research is influenced by the researcher, who she/he is as a person and their position in society (Etherington, 2007; Moser, 2008). Who *I am* (gender, age, cultural background, values and emotions etc.) and my social position (class, education, professional experience etc.), have all contributed to how I have written this thesis and to the conclusions I make. The theory and practice of reflexivity is rooted in feminist theory which is concerned with promoting equality and challenging power imbalances (Dominelli, 2002). In reflexive research, researchers are challenged to be transparent about their values and beliefs, to ‘let slip the cloak of authority,’ in order to dispel any illusions of power between the researcher and the researched (Etherington, 2007: 600). Disentangling power relationships in the research process involves a methodology which utilises one’s “self” as a reflexive tool. Practising reflexivity, challenges ‘us to be more fully conscious of the ideology, culture, and politics of those we study and those we select as our audience’ (Hertz, 1997: 5).

Reflexivity is also rooted in the theory and practice of psychotherapy. It involves noticing ‘our responses to the world around us, to stories, and to other people and

events, and to use that knowledge to inform and direct our actions, communications, and understandings' (Etherington, 2007: 601). In the context of research, it means being aware of 'the personal, social, and cultural contexts in which we (and others) live and work and to understand how these affect our conduct, interpretations, and representations of research stories' (ibid.). Etherington sums up her perspective on reflexivity in the following statement:

Reflexivity is . . . a tool whereby we can include our "selves" at any stage, making transparent the values and beliefs we hold that almost certainly influence the research process and its outcomes (ibid.).

Being transparent about who I am and my research story will show something of my thinking processes, my beliefs, values and assumptions. This will not only allow me to reflect upon how who I am might affect my research, but also enable the reader to more ably critically evaluate my research. Beyond telling my background story, reflexivity may be an important tool in every stage of the project – the literature review, interviewing, transcribing, analysis and writing up the findings. I ought to consider how my positionality, personality, values and emotions impact upon the construction of data (Moser, 2008; Finlay, 2003).

While I hope that being reflexive will expose power imbalances and personal bias, it would be idealistic to think that power imbalances or bias could be removed. According to Mies, research cannot be 'value-free, neutral, [and] uninvolved' (1992: 67). Similarly, Moser proposed that 'there are no neutral observers and no research is completely unbiased' (2008: 384). Nor is practicing reflexivity a guarantee of a more

truthful or valid research. Pillow (2003) suggests that the best that can be hoped for is a 'reflexivity of discomfort', which 'seeks to know while at the same time situates this knowing as tenuous' (188).

Personal belief system

Personal belief systems are rooted in a person's cultural background and personal experience (see Ch. 5.3 for a full discussion). They are usually a core component of a person's sense of self and are imbued with a sense of worth and emotion. When a researcher is investigating something as subjective and potentially sensitive as beliefs, I believe that being transparent about one's own beliefs is essential. My personal belief system is rooted in my upbringing in a religious Christian Protestant community in the Republic of Ireland. At a young age I adopted a Christian faith which was morally conservative and theologically evangelical. My faith was influenced particularly by being the son of a Presbyterian minister. My faith has evolved over the years through being exposed to various ideas, but I still hold generally conservative Christian beliefs. I will be in a position of power in my research interviews and must therefore be conscious of imposing my beliefs onto my participants. However, I believe it is ethical to disclose one's beliefs when asked, as part of a mutual, respectful dialogue. I trust that this perspective has allowed me to be open-minded and non-judgemental towards the personal beliefs that my participants have generously shared with me.

Attitude towards substance use

My attitude towards drug use has been influenced by my family culture, the community which I was brought up in and my Christian faith. My family were teetotal, and within the religious Protestant community drinking alcohol and smoking nicotine were taboo activities. I believe this was, at least in part, due to the influence of the temperance movement in Ireland. Part of my early Christian understanding was that being a Christian meant rejecting sinful habits, including drinking alcohol and taking drugs.

My first exposure to significant alcohol and drug use was when socialising with a group of mostly Roman Catholic friends as a teenager. Nicotine, alcohol, cannabis, speed and ecstasy among other drugs were taken in abundance. At that time, the only psychoactive substance I partook of was caffeine. I was therefore a sober observer. While my friends seemed to enjoy their substance use, my concern for them grew over time. I was worried that they were damaging their health – physical, mental and spiritual. Some years later I found out that at least a couple of these friends had suffered from depression which, rightly or wrongly, they attributed to their excessive drug use.

My perspective of psychoactive substances remained much the same throughout my university education, where alcohol, nicotine and cannabis were commonly used among my student friends. From my late 20s and during my 30s, I worked in an emergency access supported hostel for men and women and then in a residential centre for men with drug and alcohol problems. In these work contexts I met and got

to know people with serious substance use problems, which affected their physical, mental, social and spiritual wellbeing. Some of these people, who I came to know as friends, died chiefly because of their excessive substance use.

Like my personal belief system, my view towards substance use has evolved over the years - through the values of my cultural background and my various encounters of observing people using substances. Though I now drink alcohol from time to time, I think that it is unlikely that I will ever be a user of 'illicit' drugs. While I am aware of some of the benefits of drug use, my personal encounters with people for whom substance use has become problematic means that I retain a negative association with substances. My perception of substance use has emotional associations when I think about the people I've met whose lives have been diversely affected by problematic substance use. I believe my perspective has some advantages in researching recovery. I have some insight into the types of harm associated with problematic substance use and my emotional experiences may help me to empathise. On the other hand, my lack of experience of drug use may hinder my insight into many of the drug using experiences recounted by my participants. Also, growing up in a culture where substance use was seen as a transgression, I could be accused of being more open to standing in judgement. I would hope that my personal friendships and professional relationships with drug users over the years has softened any vestige of moral judgement and been replaced with a sense of shared humanity and frailty.

Educational and professional background

My professional and educational background have provided me with a particular perspective on the topics of my PhD. My formal education is multidisciplinary, including courses in media and popular culture, theology, social care, addiction and social work. In different ways, influences from my education appear in how I have approached this PhD. My professional experience in social care (homelessness and addiction recovery) also give me a specific angle on this project. The multi-disciplinary nature of my topics of interest provided various avenues of academic discipline for me to pursue. I was offered the opportunity to research within a department of theology and religion but I chose to study within Social Work at the School of Social and Political Science in the University of Edinburgh. It is clear to me that the subject area, school and university under which I have conducted my research have had a significant impact on how it has evolved. I have been, in some senses, constrained by the standards, values and norms of my institutional setting. However, within this framework I have the capacity to express some of the insights provided by my diverse educational background.

I have come to this research project largely as an outsider – I have no personal experience of problematic substance use or recovery. Yet I feel deeply connected to people who have experiences of problematic substance use through the friendships I have made with such people, on a personal and professional level. I came to this project as an outsider in that I was not a registered social worker. It could be argued that my social care background has given me both a first-hand insight into the

phenomena of problematic substance use and perhaps a more critical perspective on social work. Yet, my experience of studying and researching within a community of social work academics and social workers has made me more of an 'insider'. Dwyer and Buckle (2009) have suggested that insider/outsider is an unhelpful dichotomy and membership of a particular group does not equate to sameness. I would argue that there are pros and cons to my background and experience (or lack of), but I believe that being reflexive and transparent in my research will show my research for what it is (discussed further in Ch. 3.7).

3.2 Philosophical Assumptions and Theoretical Approach

The decisions I have made in my research design and the methods I have chosen have been influenced by a range of philosophical assumptions. I will now discuss these under the headings, ontology, epistemology and paradigm. I will also discuss the theoretical approach to research that I have chosen - the abductive research strategy.

3.2.1 Ontology

Ontology, originating from the Greek for being, *ont*, is the philosophy of the nature of being. It is concerned chiefly with what exists, what kinds of things exist, and how different kinds of being relate to each other (Bunnin and Jiyuan, 2004a). For the social researcher it concerns addressing the question, '[w]hat is the nature of social reality?' (Blaikie, 2007: 13). In theories about the nature of reality, there are two diametrically opposed categories that represent the extremes of ontological position – *realist* and

idealist. In realist theory, ‘both natural and social phenomena are assumed to have an existence that is independent of the activities of the human observer,’ while idealist theory ‘assumes that what we regard as the external world is just appearances and has no independent existence apart from our thoughts’ (ibid.). There is a range of ontological variations including, shallow realist, conceptual realist, cautious realist, depth realist, idealist, and subtle realist (Blaikie, 2007).

The ontology I have adopted incorporates aspects of both realism and idealism. In common with realist assumptions I believe that there is an external world “out there”, some of which can be perceived through the human senses. In common with idealist assumptions, I believe that our perception of the world, particularly society, is mediated through human understanding and representations. We give our world shape and meaning through language, ideas and culture. To take idealism to its limit, and say that the world does not exist outside of our social constructions is, I believe, a step too far. I would suggest that this form of idealism is both arrogantly (or perhaps naïvely) anthropocentric and socio-centric (i.e. it gives unbalanced attention to the social aspects of life to the neglect of other elements, such as the natural world).

My ontology also includes one aspect of existence that is neglected in both realist and idealist philosophies - that of the spiritual world. The spiritual world is neither something that can be observed through empirical observation nor something which is constructed through human enterprise (although religion or spirituality may be). This omission highlights that realism and idealism are secular, ethnocentric, Western

concepts that do not fit well with the worldviews of many non-Western cultures, where the spiritual world is taken for granted as a reality (Graham, 2002; Furness and Gilligan, 2010). My ontology is perhaps closest to what Hammersley, in his discussion of ethnography, describes as subtle realism:

[S]ubtle realism retains from naïve realism the idea that that research investigates independent, knowable phenomena. But it breaks with it in denying that we have direct access to these phenomena, in accepting that we must always rely on cultural assumptions, and in denying that our aim is to reproduce social phenomena in some way that is uniquely appropriate to them. Obversely, subtle realism . . . [recognizes] that all knowledge is based on assumptions and purposes and is a human construction, but it rejects [the] . . . abandonment of the regulative idea of independent and knowable phenomena. Perhaps most important of all, subtle realism is distinct . . . in its rejection of the notion that knowledge must be defined as beliefs whose validity is known with certainty (Hammersley, 1992: 52)

To summarise, subtle realism supposes a belief in an external reality that is independent from the observer and in some sense knowable; however, our knowledge of the world is veiled by human assumptions and purposes - those ingrained in our language, ideas and cultural expressions. Our knowledge of the world is therefore always in flux.

3.2.2 Epistemology

Epistemology, comes from the Greek *epistēmē*, meaning knowledge. One's epistemology is one's theory of knowledge. Epistemology is concerned with the origin of knowledge, the relationship between experience, reason and knowledge,

and the nature of truth, experience and meaning (Blackburn, 2008). Simply put, epistemology is 'the branch of philosophy concerned with enquiry into the nature, sources and validity of knowledge' (Grayling, 2002). In traditional philosophy there are two main schools of epistemological thought, *empiricism* and *rationalism*. Rationalism relies on processes of reason and logic to understand reality. Empiricism relies on sensory experience to draw conclusions about the nature of reality. Notable empiricists, like Locke, Berkeley, and Hume, 'took direct acquaintance with the 'impressions' of sense-experience as their bedrock of infallible knowledge' (Scott and Marshall, 2009: 222). Rationalists, such as Descartes, Leibniz and Spinoza, 'sought to reconstruct critically the total of human knowledge by the employment of such 'pure' reasoning from indubitable axioms or foundations' (ibid.). Empiricism is closely linked to the concept of *objectivism*. A researcher who has an objectivist perspective considers the object/s of study to have intrinsic meaning which she or he aims to uncover through empirical methods (Blaikie, 2007). Rationalism is linked with the concept of *subjectivism*, by which a researcher imposes meaning on the object/s of study (ibid.).

The modern physical sciences have historically favoured an empirical or positivist approach. Empiricism is still present in the social sciences but many alternative epistemologies have emerged. These include, relativism, conventionalism, phenomenology, critical realism, post-structuralism, metaphysical idealism and epistemological agnosticism (Scott and Marshall, 2009). In his discussion of social enquiry, Blaikie (2007) categorises epistemologies somewhat differently. The

epistemologies he discusses are empiricism, rationalism, falsificationism, neo-realism, constructionism and conventionalism. The epistemology that I believe fits best with my philosophy of social reality is *constructionism*.

Social constructionism was formally introduced to sociology through *The Social Construction of Reality* (Berger and Luckmann, 1966). Social constructionism proposes that social reality is constructed through human society and culture. Society is therefore a human product that 'continuously acts back upon its producer', and there is 'no social reality apart from man' (Berger, 1973: 13, 16). Constructionism describes the process humans use to give meaning to their existence. Constructionism can be thought of in terms of the individual or of society. The meaning-giving activity performed by individuals through their thinking, their cognitive processes, is often called constructivism or radical constructivism. Social constructionism, however, refers to the meaning-giving that is social, the 'intersubjectively shared knowledge,' which focuses on, 'the collective generation and transmission of meaning' (Blaikie, 2007: 22). Processes of constructionism are applicable to both the researcher and the participant in social research. Social actors, 'conceptualize and interpret their own actions and experiences, the actions of others and the social situations,' while social scientists, 'socially construct their knowledge of social actors' realities, their conceptions and interpretations of the actions of social actors and of social situations' (ibid: 22, 23). Blaikie explains social constructionism in the research process as such:

Constructionist social scientists argue that because it is impossible for fallible human beings to observe an external world - if one exists at all - unencumbered by concepts, theories, background knowledge and past experiences, it is impossible to make true discoveries about the world. There can be no theory-free observation of knowledge. The activities involved in constructing knowledge occur against the background of shared interpretations, practices and language; they occur within our historical, cultural and gendered ways of being. In short, as all social enquiry reflects the standpoint of the researcher, and all observation is theory laden, it is impossible to produce theory-free knowledge (2007: 23).

According to Berger's original model of social constructionism, man is both the source and the product of human society. If taken literally this is an intrinsically anthropocentric theory. Berger incorporates human biology as one of the underlying factors in the construction of human society, but the theory neglects the broader impact of ecology. Social constructionism is also characteristically Modernist and Western in that it compartmentalises the social from other aspects of life. Non-Western cultures tend to have a more holistic view of the world, incorporating the spiritual (Patel, et al., 1998; Graham, 2002). In view of these criticisms of social constructionism, I ascribe to a broader version of constructionism which acknowledges multiple types of influence – social, cultural, historical, economic, biological, psychological, environmental, ecological and spiritual.

The possibility of incorporating a spiritual dimension within a constructionist epistemology was suggested by Berger (1973). Berger claims to adopt a functional conception of religion following Durkheim (1995). Berger says religion is 'the human enterprise by which the sacred cosmos is established . . . [b]y sacred is meant here a quality of mysterious and awesome power, other than man yet related to him, which

is believed to reside in certain objects of experience' (1973: 34). The quality of sacredness is 'assigned', 'transformed', 'endowed with', 'apprehended' and 'posited' by human cognition (35).

In respect to how religion should be studied Berger (1973) adopts a position of '*methodological* atheism' (106). He says that religious projections should be viewed as merely products of human action and thought and questions about transcendence should be bracketed. Berger, however, seems to step outside these brackets to suggest that human religion points to something *other* (also see Berger, 1970: 70):

[T]o say that religion is a human projection does not logically preclude the possibility that the protected meanings may have ultimate status independent of man. Indeed, if a religious view of the world is posited, the anthropological ground of these projections may itself be the reflection of a reality that *includes* both world and man, so that man's ejaculations of meaning into the universe ultimately point to an all-embracing meaning in which he himself is grounded (1973: 182, 183).

Other scholars of religion have suggested that *methodological agnosticism* is more appropriate than *methodological atheism* (Smart, 1977; Hamilton, 2001). I would agree with this since the use of the term 'atheism' suggests that a pre-judgement has been made. In conclusion, I have adopted a broad constructionist epistemology which incorporates the influence of the spiritual as well as other factors. Since I do not plan to make judgements about the transcendental reality of my participants' religious, spiritual or other existential beliefs, practices or experiences it could be said that I am adopting a position of methodological agnosticism.

3.2.3 Paradigm

My methodology has also been influenced by the paradigms I have encountered in social research, especially through my institution and the academics I have studied and worked with. The concept of paradigm, from the Greek *paradeigma*, meaning model or pattern, was popularised by Thomas Kuhn in *The Structure of Scientific Revolutions* (1962/2012). Kuhn uses the term paradigm to 'refer to a framework of concepts, assumptions, and approaches within which members of a scientific community conduct their research' (Bunnin and Jiyuan, 2004b). Kuhn says,

Close historical investigation of a given speciality at a given time discloses a set of recurrent and quasi-standard illustrations of various theories in their conceptual, observational, and instrumental applications. These are the community's paradigms, revealed in its textbooks, lectures, and laboratory exercises (Kuhn, 1962/2012: 43).

In the community of natural science research, normative theories and practices are largely dictated by the paradigm of that time. The social sciences have historically been more diverse, featuring multiple paradigms. Blaikie (2007) defines research paradigms in the social sciences as,

Broad philosophical and theoretical traditions within which attempts to understand the social world are conducted. They provide different ways of making connections between ideas about the social world, the social experiences of people and the social world within which social life occurs (2).

Blaikie (2007) groups social science paradigms into two groups, classic (positivism, critical rationalism, classical hermeneutics and interpretivism) and contemporary

(critical theory, ethnomethodology, social realism, contemporary hermeneutics, structuration theory, feminism). Traditional social work research was dominated by a positivist perspective (Farmer and Bess, 2010). Positivism has been criticised for favouring the views of white Western men. Positivism is still evident in social work research, but contemporary social work research has been influenced by alternative paradigms. Farmer and Bess (2010) highlight three of the most influential paradigms in social work research: feminist, ecological and empowerment perspectives. The feminist approach aims to 'develop versions of reality that more accurately reflect the experience of women, versions that affirm women's strengths and value and can transform society itself' (Davis, 1994: 65). Feminist research aims specially to highlight the power imbalances that women and other disempowered groups (e.g. ethnic minorities, subcultural groups) experience in society. Researchers influenced by feminism adopt various quantitative and qualitative methodologies, but qualitative methods which empower participants through giving them voice tend to be favoured (e.g. semi-structured interviews, ethnography, action research).

The ecological perspective takes the person's environment or context into consideration. It is in harmony with constructionist research in that it presumes there are multiple viewpoints within any one context. The ecological view considers how knowledge can be co-constructed by all those involved in the research process (research respondents, researchers, and other stakeholders) (Farmer and Bess, 2010).

Empowering perspectives are related to theories of feminism and anti-discriminatory and anti-racist social work (Thompson, 2006; Adams, 2008; Dominelli, 2008). In this approach the researcher aims to empower the research participants, especially those who have been disempowered within society. Participatory action research lends itself to this paradigm (McNicoll, 1999). Feminist, ecological and empowering research paradigms are all closely related in their aims and favoured methods. These paradigms have influenced my research design and methodology. This is evident in my adoption of reflexivity, a qualitative method, constructionist theory and narrative analysis.

3.2.4 Research Strategy

A research strategy or *logic of enquiry* can be thought of as the 'processes required to answer research questions, to solve intellectual puzzles, [and] to generate new knowledge' (Blaikie, 2007: 2). In the social sciences there are four distinct research strategies that have traditionally been employed:

- *Inductive* – Starts by accumulating and observing data, and producing generalisations. Aims to establish universal generalisations to be used as a pattern of explanations. Finishes with using these 'laws' as patterns to explain further observations.
- *Deductive* – Starts by identifying a regularity to be explained, constructing a theory and deducing hypotheses. Aims to test theories, to eliminate false ones and corroborate the survivor. Finishes with testing the hypotheses by matching them with data.

- *Retroductive* – Starts by documenting and modelling a regularity, constructing a hypothetical model of a mechanism. Aims to discover underlying mechanisms to explain observed regularities. Finishes with finding the real mechanism by observation and/or experiment.
- *Abductive* – Starts by discovering everyday lay concepts, meanings and motives, producing a technical account from lay accounts. Aims to describe and understand social life in terms of social actors' motives and understanding. Finishes with developing a theory and testing it iteratively (Blaikie, 2007: 8).

I believe the research strategy that fits best with my project is the abductive approach. It involves, 'constructing theories that are derived from social actors' language, meanings and accounts in the context of everyday activities' (Blaikie, 2007: 89). An abductive strategy begins with the description of activities and meanings, and subsequently derives categories and concepts which may be the basis for understanding or explanation. The abductive strategy is underpinned by an idealist ontology and a constructionist epistemology. However, it is also compatible with a subtle realist ontology (Blaikie, 2007).

The abductive strategy respects the view of the research participant as an 'insider'. The researcher's task is not to impose her or his views on the objects of study, but to discover and describe how the insider makes sense of her/his world. The aim is therefore to 'discover why people do what they do by uncovering largely tacit, mutual knowledge, the symbolic meanings, intentions and rules, which provide the orientations for their actions' (Blaikie, 2007: 90). In the abductive method, the

researcher gains access to the social world through participants' accounts of their own and others' actions. The theories and concepts that participants use to structure their world are contained in their accounts. Much of social life is conducted in a way that is routine, taken-for-granted and unreflective, and so a participant may only begin to interpret and construct their actions, meanings and theories, 'when enquiries are made about their behaviour by others (such as social scientists), or when social life is disrupted, and/or ceases to be predictable' (ibid.).

3.3 Sampling and recruitment

In this section I discuss my sampling theory, the characteristics of my sample and how I recruited my sample. I take a critical approach to sampling theory, adopting Lincoln and Guba's (1985) model of naturalistic sampling, and the method of purposive sampling (Oliver, 2006).

Sampling theory and sample characteristics

The group of people that I am interested in in this project are people who have recovered from problematic substance use in Scotland. Within the tradition of positivistic social science, the group of individuals who become the subjects of study are normally referred to as the sample. In this regard, a sample may be thought of as 'a selection of elements (members or units) from a population' that may be used to generalise about the whole population (Blaikie, 2010: 172). A population may be understood to be 'an aggregate of all cases that conform to some designated set of criteria' (ibid.). Within this paradigm, the usual sampling technique is simple random

sampling, drawing inferences using statistical methods. Lincoln and Guba (1985) suggest that this approach is problematic because its bias fails to account for heterogeneous characteristics and contexts. This is reflected in their statements of positivist and naturalist perspectives on 'The possibility of generalization' from a sample.

Positivist version: The aim of inquiry is to develop a nomothetic⁶ body of knowledge in the form of generalizations that are truth statements free from both time and context (they will hold anywhere and at any time).

Naturalist version: The aim of inquiry is to develop an idiographic⁷ body of knowledge in the form of "working hypotheses" that describe the individual case (Lincoln and Guba, 1985: 38).

Lincoln and Guba make a distinction between positivist sampling, and what they call naturalistic sampling. They elaborate that the purpose of naturalistic sampling, 'is not to focus on the similarities that can be developed into generalizations, but to detail the many specifics that give the context its unique flavor . . . Its purpose is to maximize information, not facilitate generalizations' (Lincoln and Guba, 1985: 201, 202). I have chosen to adopt the model of naturalistic sampling as I believe it is consistent with my methodology: case-centre inquiry with a narrative emphasis. This theoretical approach omits the possibility of statistically valid generalisations, but it opens up the

⁶ Nomothetic - from the Greek, *nomos*, meaning law, indicating the aim of establishing laws or generalisations.

⁷ Idiographic - from the Greek, *idios*, meaning own or private, indicating a focus on the unique characteristics of a case.

possibility of providing rich contextual data that provides insight into heterogeneous variations. I will explore the practical benefits of my research more fully in chapter 3.7.

There are various sampling methods which may be chosen depending on practical considerations and theoretical perspectives. Despite the theoretical issues with simple random sampling, this method is unrealistic with hard-to-reach populations. People with a history of problematic substance use are notoriously difficult to locate. This is due partly to the associated social stigma, and the associated illegal status of many drugs. Also, while many people may have had contact with professional agencies (health and social care, police and prison), a significant number of people who have experienced recovery from problematic substance use may have done so without any professional support (e.g. Stall and Biernacki, 1986). There are therefore no comprehensive lists of people in Scotland who are in recovery.

The main sampling method I have adopted has been called *judgemental or purposive sampling* (Oliver, 2006). Blaikie (2010) suggests that this method is useful when it is impossible or too costly to identify a particular population, giving intravenous drug users as an example. I also make use of snowball sampling, also known as network or chain referral sampling (Biernacki and Waldorf, 1981; Blaikie, 2010). This method can be particularly useful for accessing hard to reach populations, such as illicit drug users. Snowball sampling functions by asking initial participants to ask people they

know, who may be eligible, if they would like to participate in the research. I facilitated this process by giving interviewees project leaflets at the end of interviews.

The size of my sample was influenced by three main factors: theory, constraints of time and resources, and responses. Firstly, I needed to ensure that my sample was large enough on which to build my theory. I needed enough variety and depth of data from my sample to ensure that I could address my research questions to a satisfactory degree. In this sense, it could be said that my sampling practice was informed by the theory of *theoretical sampling* (Glaser and Strauss, 1967). Blaikie (2010) describes the process as such:

The initial case or cases will be selected according the theoretical purposes that they serve and further cases will be added in order to facilitate the development of the emerging theory. As theory development relies on comparison, cases will be added to facilitate this. An important concept in this process is 'theoretical saturation'. Cases are added until no further insights are obtained; until the researcher considers that nothing new is being discovered (179).

However, my sampling method departs from theoretical sampling at the ideal of *theoretical saturation*. The second factor, constraints of time and resources, meant that I had to limit my sample size to twenty participants. I may well have obtained further insights with more participants and more time and resources. Thirdly, I was limited by the response rate. At the beginning of the project I had a steady flow of volunteers, but over time this slowed. I had to make extra efforts to identify the last few participants. Again, with more time and resources, I may have been able to recruit more volunteers.

In making decisions about my sample, I also needed to consider the particular characteristics that I required of my participants. The specific criteria I decided upon for my sample are as follows: resident in Central Scotland; a variety of gender, ethnicity and social class; 18 years of age or older; a history of problematic substance use (specifically alcohol and heroin); experience of recovery; and a range of beliefs. I will now discuss my rationale for choosing these particular criteria.

The geographical focus of my research is Scotland. My particular interest in problematic substance use, recovery and belief in Scotland has been influenced by personal experiences of living in Scotland, and specifically my work with people with substance problems. My research has been inspired, in part, through a realisation of the lack of studies about problematic substance use in Scotland. My hope is that my research will build upon the evidence-base for recovery in Scotland. I have chosen to draw my sample from the area of central Scotland, chiefly in and around Edinburgh. This choice is based on two key factors. Firstly, the practical considerations of limited resource and a restricted time frame suggested travel for interviews should be minimised. This had to be balanced with the second factor; the likely difficulty of accessing a sample in one area.

My hope was to gather a diverse range of individuals in terms of gender, ethnicity and social class in order to present a picture of the range of recovery experiences. I chose to limit the age range of my sample to include only those who are adults (over 18 years of age). This is partly to avoid the ethical complications of working with

children. Also, those individuals who develop problems with substance use in their youth are still early in their drug-using careers and serious problems often don't emerge until adulthood. By default, young people who have recovered have only had a short history of problematic substance use and probably cannot contribute much to an understanding of how people with prolonged and severe problematic substance use can recover.

In my sample, I was looking for individuals who had a history of problematic substance use. Rather than assess or screen my sample for criteria for problematic substance use, dependence or addiction, I chose to let them self-define their substance use as problematic. While I was aware that many drug users in Scotland use multiple drugs (poly-drug use), in my recruitment literature I chose to specify alcohol and heroin since both are central to problematic substance use in Scotland and have been the focus of particular research (Scottish Government, 2008b; Best et al, 2010). I also thought that these two categories could enable easier comparison between types of substance users. In reality, poly-drug use among my participants made this comparison difficult.

I also wanted to interview people who were in recovery or who had recovered from problematic substance use. I deliberately chose not to seek people associated with any particular treatment approach, institution, or community (such as AA). As my research title suggests, I am interested in the various pathways to recovery in

Scotland. Recovery pathways may involve contact with modalities of treatment, or perhaps none at all (White and Kurtz, 2006; Stall and Biernacki, 1986).

There was also the issue of how participants might understand recovery. Different individuals may define recovery in different ways. Some may say they are in recovery, some may say they are recovered, while others prefer to use a different term to describe their altered relationship with substances. Some individuals may equate recovery with total abstinence from all drugs or from the drug/s that were problematic to them, while for others controlled use of a drug/s may equate to recovery. Rather than not recruiting people who might not comply with my understanding of recovery, I allowed participants to decide what recovery meant for them.

In my recruitment literature, I asked for participants who had least 12 months of recovery experience. Recovery has been categorised into three main stages: early recovery, 0-1 years; sustained recovery, 1-5 years; and stable recovery, 5 years + (Betty Ford Institute Consensus Panel, 2007). I discerned that people with at least one year of recovery experience could provide good insight into recovery.

I was also hoping to find a range of beliefs represented in my sample. This was not something I could realistically control for a number of reasons. Firstly, my challenge in finding a large enough sample meant that I couldn't select who I wanted. Secondly, the potentially sensitive nature of beliefs makes it difficult to assess this at the outset

of the engagement. Thirdly, I was interested in the nuances of beliefs, some of which may not be easily categorised.

Recruitment process

For the purpose of recruitment, I designed a letter and poster (see appendices 12.1 and 12.2). I sent these to a range of treatment agencies (including NHS, statutory social work and voluntary sector services) and recovery community groups around Edinburgh, the Lothians and Glasgow. The agencies and communities were for alcohol, drugs or both. The letter asked the agency or group to post the poster in their premises if possible and to draw attention to the project to anyone who might be interested. I also followed this up by a phone call to ensure they had received the information. I used web-based social networking platforms for certain recovery communities to post the recruitment poster and I distributed leaflets at a national recovery community event on one occasion.

During a second wave of recruitment, I contacted services that worked with ethnic minority groups and a range of belief-focused institutions and resources (e.g. chaplains, churches and temples). To facilitate snowball sampling I gave my participants leaflets to pass on to anyone they thought might be interested. Two participants were recruited through suggestions from people I met. In these cases, they contacted the person on my behalf or I contacted them (in one case, as the person had a public profile). Three participants were recruited through personal encounters.

Most volunteers contacted me by telephone or by email. When I spoke to volunteers over the phone I asked them only basic information in order to arrange a time and place to meet. While I had designed a screening questionnaire (appendix 12.4), I determined that it would be unethical (and socially awkward) to ask for personal details over the phone. At this point I asked them for an email address to send them an information sheet and consent form (appendices 12.3 and 12.5). Once they had received these I contacted them again to confirm that they understood what was involved in the research process. If they were still happy we went ahead with the interview. On a number of occasions individuals expressed an interest in participating but subsequently changed their minds.

Reflection on sample and recruitment

What I had designed as a screening questionnaire, became a form used to collect demographic and other basic information about my participants. In the early stages of the interviews I followed the contents of the form with participants. After further iterations of the interviews, I felt it was an inappropriate way to start an interview. Instead, at the end of the interview if there were still gaps in the form, I would ask them to supply the details I was still lacking. Table 1 provides an overview of my sample's characteristics based on the information I collected in the screening questionnaire.

Table 1: Sample Characteristics (20 participants)

Primary drug	No. of participants
Alcohol	11
Heroin	9
Both	9
Poly drug (more than 2)	16
Gender	
Female	10
Male	10
Age	
Range	31-60
Mean	47.4
Nationality	
Scottish (just)	11
British (just)	7
Scottish/British	1
British/English	1
Ethnicity	
White	8
Caucasian	1
None stated	11
Location	
Edinburgh	10
Mid or East Lothian	4
Fife	1
Glasgow	5
Contact source	
Recovery community	5
Personal encounter / direct approach	5
Recovery organisation	6
Self-help recovery organisation	1
Voluntary sector agency	1
Health agency	1
Inter-agency recovery hub	1
Current type of employment	
Addictions/recovery worker/counsellor	10
Social worker	1
Retail	1
Labourer / Skilled labourer	2
other	1
Unemployed	4
Retired	1

Highest level of Education (completed or working towards)	
Secondary	2
Further (certificates, diplomas, NVQs)	12
Higher	3
Postgraduate	3

In terms of the primary drug used among my participants there were just two more alcohol users (11) than heroin users (9). Nine participants used both drugs and sixteen used multiple drugs. Comparing alcohol users with heroin users would make for neat science in principle but the commonality of poly-drug use makes this problematic. There was an equal balance between male and female (transgender people were not represented as far as I am aware). Ages ranged between 31 and 60, the mean age being 47.5. The lack of younger drug users in recovery (18-30) could be due to many factors. Two possible reasons could be: it may suggest that those who use problematically may have not reached the point where they see their drug use as problematic; or some with problematic substance use may still be in early recovery and possibly feel they do not have much to contribute to research on recovery or belief. The lack of older people could again be for many reasons. Some may have died early due to problematic substance use; some may have limited contact with services or communities due to their age; they may have seen themselves as post-recovery; or perhaps they felt that their memories of recovery were too vague.

All of my participants identified themselves as Scottish, British, English or a combination of these. All of those who answered my question about ethnicity

identified themselves as white or Caucasian. Only one participant diverged from this ethnic profile, having an African-American father. In a second wave of recruitment I made efforts to find some volunteers from ethnic minority (EM) groups by contacting specialist EM services and minority religious leaders (e.g. an Iman). One conversation I had with a specialist worker made it clear to me that there were people in that community who had suffered from substance use problems and some that had recovered with the help of religious resources. I predicted that it would be a challenge to find participants from EM groups, not only because of the relatively small population of EMs in Scotland (National Records for Scotland, 2013), but because they are under-represented in substance misuse services (EMEDI, 2006). There are various reasons for this, but associations of shame and stigma with drug use in EM cultures is one of the main obstacles to people talking about their problematic substance use (ibid.). While having participants from EM cultures would have enriched my data, it would also have made it more complex. Exploring problematic substance use and recovery among minority ethnic groups could be better explored in separate studies.

All of my participants came from the Scottish central belt with half coming from Edinburgh, five coming from the Lothians and Fife and five from Glasgow. In reality all hailed from different parts of Scotland and England and they had moved between different locations during their periods of problematic substance use and recovery (international locations in one case). Although different areas in Scotland have different drug and recovery cultures it is hard to draw conclusions about the impact

of these cultures on any person if that person frequently moves between different places. While I am interested in the diversity of recovery experiences in Scotland, I can draw only limited conclusions with such a small sample with limited geographical scope.

Over half of my sample made contact through a recovery organisation or community. Health agencies and social work agencies were underrepresented. One health agency felt they could not display my publicity because it was not covered by NHS research ethics. This is likely to have been a reason for other NHS services not participating. One social work agency felt that their services users had been over-researched recently. Local authority organisations may also have felt uncomfortable advertising research that had not passed their council's ethical procedure. One recovery organisation was highly supportive of my research and put me in contact with numerous people, six of which became participants. To an uninformed onlooker this may indicate a significant bias towards people who were engaging with this organisation, in reality, these participants represented a broad range of recovery pathways and styles, and they had recovered through the support of many different types of agencies and organisations.

Current type of employment and highest level of education gives some indication of the social class of my sample. If one uses education as the main indicator of class, 14 would be classified as working class. Most of those with a higher or postgraduate level of education had worked their way up socially through professional training and

employment in the therapeutic and social care industries. Only one person had a job with a professional status before their recovery. A number of participants were in the process of education or training. This suggests an association between progress in recovery and social mobility. The fact that over half of the sample were working in the therapeutic or social care/work industries also says something about pathways to recovery, or it may be indicative of the type of people in recovery who are more ready to talk about their recovery, or just easier to find because of their employment status.

In my screening questionnaire (appendix 12.4), I also planned to note how long people had struggled with problematic substance use and how long they had been in recovery. After further reflection I realised that the first category was impossible to define. Participants could roughly remember when they took a particular substance for the first time, but saying when it became a problem was very hard to define. To further complicate calculating a timeframe, some people had long periods of abstinence between periods of problematic substance use. Similarly, asking people to define when their recovery began was problematic. For those who equated recovery with abstinence, this was an easier calculation to make. While timeframes for recovery are somewhat arbitrary they give a general picture of recovery maturity. I was looking for participants who had been in recovery for at least 12 months. 19 of the sample ranged from approximately 16 months to 35 years (mean, 7.7 years). One participant had been in recovery for only 6 months. This was the consequence of not

conducting formal screening. However, this participant provided a unique insight into recovery within my sample.

3.4 Data collection

In making a decision about my chief method of data collection, there were many possible options. In the social sciences, methods are generally thought to be either quantitative or qualitative. Quantitative methods include self-administered questionnaires, structured interviews and structured observations. Qualitative methods include ethnographic observations, semi-structured interviews, oral histories and focus groups (Blaikie, 2010). Each method, whether quantitative or qualitative, has advantages if the research aims, theories and strategy fit. For the purposes of my research, I chose to use in-depth semi-structured interviews, influenced by narrative theory (subsequently referred to as narrative interviews). In this chapter I will define narrative interviews and how I implemented them; discuss the theory I have employed in this method; explain my rationale for using narrative interviews; and outline the limitations of this approach.

3.4.1 Defining and implementing narrative interviews

I use the term *narrative interviews* as shorthand for in-depth semi-structured interviews, influenced by narrative theory. Semi-structured interviews are a well-established method in the social sciences, commonly involving a one-to-one conversation, led by a researcher using an interview schedule (Mason, 2002). The interview is usually initiated by the researcher and conducted according to the

particular research agenda and question/s. The interview schedule is a set of questions designed to guide the conversation and help the interviewer to meet the research agenda. In a semi-structured interview, the schedule is meant to facilitate in-depth discussion into the research topics or themes. The questions are therefore used to guide rather than dictate the conversation. This approach frees the researcher to allow the conversation to evolve by allowing the interviewee to speak and asking additional questions when clarity is needed or interest is provoked.

I designed my interview schedule to guide my interviewees through the main themes of problematic substance use, recovery, belief and social work (see appendix 12.6). Rather than asking each question systematically (as in a structured interview), I used the questions as a framework for our conversation. This allowed me to ask further questions on specific points of interest raised by the participants. I had given my participants a copy of the interview schedule prior to our meeting. Employing a narrative approach, I encouraged participants to tell their story (Elliott, 2005). In cases where they answered my set questions in the process of telling their story, I did not verbalise the questions. Even when my participants' accounts veered off into tangential stories, I gave them the freedom to share, if they felt it was important to their broader recovery narrative. Interviews were audio-recorded with the participant's consent for the purpose of in-depth analysis. I also took some written notes during the interviews in case the recording failed, and to help me to keep track of the conversation and any additional questions I wanted to ask.

3.4.2 Theorising narrative interviews

Hermanowicz (2002) argues that semi-structured interviews, 'if executed well, brings us arguably closer than many other methods to an intimate understanding of people and their social worlds' (480). Blaikie (2010) similarly proposes, that while they do not have the advantage of positioning the researcher in the natural social setting where social behaviours and interactions can be observed, in-depth interviews can 'get close to the social actors' meanings and interpretations, [and] to their accounts of the social interaction which they have been involved' (207). The semi-structured interview method fits within the theoretical framework of the research strategy which I have adopted – the abductive approach (see Ch. 3.2.4). Interviews have the potential to give insight into participants' 'largely tacit, mutual knowledge, the symbolic meanings, intentions and rules, which provide the orientations for their actions' (Blaikie, 2007: 90).

My approach to interviewing has been informed by narrative theory. Riessman (2008) notes that narrative has many meanings and uses, depending on discipline. Narrative is often used as a synonym for story. Narratives or stories in the human sciences can be provisionally defined as, 'discourse with a clear sequential order that connects events in a meaningful way for a definite audience and thus offers insights about the world and/or people's experiences of it' (Hinchman and Hinchman, 1997: xvi). Riessman (2008) is hesitant to provide a simple definition but she describes the process of storytelling as such:

[I]n everyday oral storytelling, a speaker connects events into a sequence that is consequential for later action and for the meanings that the speaker wants listeners to take away from the story. Events perceived by the speaker as important are selected, organized, connected, and evaluated as meaningful for a particular audience (3).

In this definition of everyday oral storytelling, Riessman describes a speaker, or storyteller, sharing a spoken narrative that has a sequential order. The storyteller designs the narrative, with the intention that their story will have an impact on future events, or carry their intended meaning to the listener.

From a historical perspective, the theory of narrative can be traced back to Aristotle's examination of Greek tragedy (Aristotle, 1965). In this traditional form of narrative, action was imitated (*mimesis*) through the dramatist's representations of events, experiences and emotions. There is a clear beginning, middle and end to this narrative form. Characters are secondary to the plot, which is the vehicle for producing emotion through dramatic effect. Aristotle saw Greek tragedies as moral stories, 'depicting a rupture from the expected' (Riessman, 2008: 4). They had an interpretive function, mirroring life rather than representing it exactly. This model of narrative still resonates in popular understandings of the story, from how children are taught to write stories in school, to classic novels and Hollywood movies. However, narrative theory has evolved, influenced by the literary and cultural theories of 'French structuralism, Russian formalism, poststructuralism, cultural analysis, and postmodernism' (ibid.). These changes are evident in the postmodern

narratives of popular culture in, for example, films such as *Pulp Fiction* (1994) and *Memento* (2000).

Narrative theory originally developed through the study of literature, the written word. Other 'texts' have become the subjects of narrative theory, including the spoken word and visual media. Roland Barthes (1977), commenting on the presence of narrative in a diversity of texts argues that,

narrative is present in every age, in every place, in every society: it begins with the very history of mankind [sic] and there nowhere is nor has been a people without narrative . . . it is simply there, like life itself (79).

There is something fundamental about human beings and our relationship with narrative, with stories. Stories are ubiquitous in our creations and expressions of life. While visual art may or may not be more primal than the spoken word, the spoken word came before written language, therefore it could be argued that oral stories are more fundamental to human expression than those that we write. It is these oral narratives that will be the data for my research. My recording, interpreting, (re-) ordering and writing of these oral accounts will become another narrative of sorts. Even those who read the narratives I construct will re-construct them through their own interpretation, to form their own version of the story.

In the social sciences there are differences in how narrative is operationalised but they all have the common characteristic of 'contingent sequences'. Salmon sums this up well:

A fundamental criterion of narrative is surely contingency. Whatever the content, stories demand the consequential linking of events or ideas. Narrative shaping entails imposing a meaningful pattern on what would otherwise be random and disconnected (Salmon and Riessman, 2008: 78).

Riessman discusses how narrative is operationalised methodologically across the social sciences, by comparing and contrasting the discipline of social linguistics with that of social history/anthropology. Social linguistics understands narrative as, 'a discrete unit of discourse, an extended answer by a research participant to a single question, topically centred and temporally organized' (Riessman, 2008: 5). On the other end of the spectrum, social history/anthropology sees narrative as, 'an entire life story, woven from threads of interviews, observations and documents' (ibid.). Somewhere in the centre lies the approach taken in sociology and psychology – 'personal narrative encompasses long sections of talk – extended accounts of lives in context that develop over the course of single or multiple research interviews or therapeutic conversations' (ibid: 6).

The stories that are told by my participants may, on the surface, be thought of as personal stories. Riessman suggests that the prevalence of personal stories in contemporary society reflects and produces 'the cult of "the self" as a project in modernity' (2008: 7). Riessman also wonders whether the popularity of narrative in society is linked to an obsession with "identity":

No longer viewed as given and "natural," individuals must now construct who they are and how they want to be known, just as groups, organizations, and governments do. In postmodern times,

identities can be assembled and disassembled, accepted and contested, and indeed performed for audiences (2008: 7).

3.4.3 Rationale for using narrative interviews

My rationale for choosing narrative interviews was based on multiple factors including my research aims; appropriateness for subject matter; epistemology and ontology; paradigm; research strategy; and my personality and professional background. I will discuss my rationale for choosing this method under the headings: appropriateness for research topics, emotional sensitivity, empowerment and personal bias.

3.4.3.1 Appropriateness for research topics

There is a rich tradition of using semi-structured interviews in researching problematic substance use and recovery (e.g. Waldorf, 1983; Biernacki, 1986; Hänninen and Koski-Jännes 1999; Larkin and Griffiths, 2002; McIntosh and McKeganey, 2002; Etherington 2006; Best et al., 2011). Listening to people's personal accounts provides depth of information and first-hand insight. McIntosh and McKeganey (2002), who conducted semi-structured interviews with 70 men and women in recovery, express a similar rationale for choosing this method. Semi-structured interviews allowed them to gather the 'details rather than the generalities of recovery', and gain insight into 'the process of recovery from perspectives of the addicts themselves' (2001: 7). McIntosh and McKeganey's approach, like my own, is based on the assumption that, it is people who have recovered that have the best insight into the processes involved in recovery.

Conducting semi-structured interviews, employing a narrative approach is especially suitable for researching recovery. People often recount their experiences of recovery as stories. Recovery is a process which is often framed using the metaphor of a journey. This phenomenon is evident in the storytelling traditions of Alcoholics Anonymous and other Twelve Step fellowships (Cain, 1991; Rapport, 1993; Jensen, 2000), and reflected in the research studies which focus on narratives of recovery. In addition to the literature which uses narrative to focus on recovery in general, there is a well-established literature base that explores the construction of recovery identities through narrative (e.g. Cain, 1991; Hänninen and Koski-Jännes, 1999; McIntosh, and McKeganey, 2000; Koski-Jännes, 2002; Etherington, 2006). Recovery stories usually contain the following elements:

- Beginnings - how they got involved in problematic substance use and how their lives deteriorated
- Middles - how they lived with their substance as the centre of their lives for many years and how they tried to change but couldn't
- Dramatic ruptures (singular or multiple) – how life changing events or relationships enabled them to change for good
- Personal transformation – building a new life and identity
- Endings – how their life is different now and how they have hope for their future.

The story form is also central to how people talk about their beliefs. This can be seen in stories of religious conversion (*testimonies* in the Christian tradition), spiritual enlightenment or loss of religious beliefs (Rambo, 1999; Mahoney and Pargament 2004; Pargament et al., 2005). Similar to recovery stories, in many faith stories, individuals talk of their life before, their conversion experience and how their life has

changed (it could be argued that recovery stories have their roots in stories of religious conversion or spiritual enlightenment). While only some people have a singular conversion experience, others often talk of their spirituality or other existential beliefs using sequential stories of what they used to believe, and how they came to believe what they believe now. The literature that looks at the formation of belief identities within a narrative framework also points to the appropriateness of the method (e.g. Stuber, 2000; Pop-Baier, 2001; Maruna et al., 2006). Those that study recovery, belief and identity are particularly pertinent (Engelbrecht, 2011; Sremac and Ganzevoort, 2013a, 2013b; Sremac, 2010)

3.4.3.2 Emotional sensitivity

The emotionally sensitive nature of the topics of problematic substance use, recovery and beliefs also fits well within the narrative interview approach. Recounting experiences of problematic substance use and recovery often means remembering past traumas (Etherington, 2008) and potentially unearthing deep emotions: guilt, shame, anger and resentments (O'Connor et al., 1994). Similarly, religion and spirituality can be associated with emotionally sensitive issues such as religious abuse, existential angst, bereavement or mortality (Culliford and Eagger, 2010). It could be argued that in-depth interviews can provoke emotions which might even result in a relapse. However, interviews can be conducted in a supportive and respectful manner that may result in it being a therapeutic experience for the participant (Kvale, 1996; Birch and Miller, 2000; Bondi, 2003).

3.4.3.3 Empowerment

If narrative interviews produce a therapeutic effect, it could be said that they have the potential to be empowering for participants. They may also be empowering in that they can facilitate the respectful portrayal of participant's views through giving them voice. Elliott (2005: 6) suggests that narrative interviewing gives participants a say over the pertinent themes of the research in an empowering way. In this sense, it could be said that narrative interviews conform to the values suggested by the social work research paradigms that place an emphasis on empowerment (e.g. feminism, anti-discriminatory practice, radicalism). Narrative interviewing can also be empowering for participants through balancing power relationships in the construction of knowledge, giving interviewees 'more opportunity to become active subjects' (Elliott, 2005: 135).

3.4.3.4 Personal bias

In addition to the theoretical reasons I have given for choosing semi-structured interviews, my choice has been influenced by personal bias and professional experience. Inherently, I prefer narrative accounts and conversational discourse over quantitative data. This bias has been reinforced through my professional experience of working with substance users. Most of my work involved listening to individual's personal accounts and engaging on a conversational level. I believe that much of my learning was attained through these personal encounters.

3.4.4 Limitations of narrative interviews

I have discussed some of the benefits of taking a narrative approach and why I think it is suitable for my research aims. There are, however, limitations to the narrative approach. Firstly, not everything fits within a narrative framework. I believe that there has been an idealisation of narrative methods in the social sciences that has led to narrative methods being used in an uncritical way (e.g. Atkinson, 2009). As a result, some researchers have manipulated their data into a narrative framework, even though it doesn't necessarily fit. There are other types of discourse such as reflective statements, reasoning, conventions and codes (Tilly, 2006). Riessman supports this notion when she says, 'narrative is everywhere, but not everything is narrative' (2008: 4). Riessman argues that there is a need for stricter boundaries around the concept, noting that there are other forms of oral communication including, 'chronicles, reports, arguments, and question and answer exchanges' (2008: 5).

A second key limitation to the narrative approach is the problem of memory (Gardner, 2001; Gemignani, 2014). Memory affects research data collected through interviews and oral/life histories, as well as other kinds of methods (e.g. self-completed questionnaires). Miller (2000), in reference to narrative interviewing, notes that while they are located in the present, 'remembrances of the past and anticipations of the future are constructed continuously through the lens of the present' (14). Similarly, it could be argued that imagination also plays a role in how people construct their stories. McIntosh and McKeganey (2002) make reference to the problematic nature of narrative accounts of historical events, they comment,

We are aware of the potential difficulties associated with retrospective data of this sort; for example, the problem of recall and the possibility that events and circumstances might be reinterpreted or presented in different ways that suit the individual's current presentation of self (7).

Clouded memories and vivid imaginations may affect the reliability of people's stories. There will inevitably be a disparity between what is recounted and what actually happened. This does not, however, take away from the meanings that people consider as valid.

Linked to the previous point, the third key limitation to the narrative approach is the potential to equate narrative accounts with truth, or in the language of epistemology, to make realist assumptions about narratives (Hinchman and Hinchman, 1997). This could be thought as part of the idealisation of narratives (discussed above), in that participants' narratives are thought of as a form of data that provides unadulterated insight into the real experiences of real people. Narratives should be thought of as subjective accounts, constructed by individuals, affected by memory, imagination and social context. Farias and Hense (2008), in their discussion about studying spirituality, go as far as to say that the subjective nature of narrative interviews 'may lead us further away from that which we are seeking to study, while giving the illusion that we are nearing it' (174). They suggest that narratives should only be interpreted by factoring in the social and cultural context in which they are located. Interview discourses and narratives are co-constructed between the interviewer and interviewee in a particular time and place (Riessman, 2008). This idea is articulated well by Etherington (2008: 235):

[R]econstructions of the person's experiences, remembered and told at a particular point in their lives, to a particular researcher/audience and for a particular purpose: all of which will have a bearing on how the stories are told, which stories are told and how they are presented/interpreted.

There are also questions about whether semi-structured interviews are necessarily empowering to participants or not. Finch (1984) interviewed clergy's wives and working class women involved in running and using playgroups. She found that building rapport with her participants could leave them in a vulnerable position. While less-structured interview techniques have the potential to diminish the hierarchical relationship between interviewer and interviewee, interviewees may be led to think that they are not vulnerable to abuses of power. Finch noted that holding her interviews in the participants' homes facilitated more intimate conversation and built trust but she also noted how this could open the way for a potentially exploitative relationship. The *British Sociological Association's* statement of ethical practice (BSA, 2002) states that, 'while some participants in sociological research may find the experiences a positive and welcome one, for others, the experience may be disturbing. Even if not harmed, those studied may feel wronged by aspects of the research experience' (4).

3.5 Analysis

There is a variety of analytical methods commonly used to analyse data from semi-structured interviews, including grounded theory, narrative analysis and content analysis (Bryman, 2008; Silverman, 2000). My choice of analytical method was

informed by my research aims, my philosophical assumptions, my method of data collection and by practical constraints. I was drawn to narrative analysis since it seemed to be the best fit for my constructionist epistemology, and the narrative approach underpinning my interview method. I also thought that the method showed respect for my participants' stories and it was less likely to fragment and de-contextualise their accounts than other forms of data analysis. As I was interested chiefly in the content of my participants' accounts, I chose to adapt what Riessman (2008) has called thematic narrative analysis (TNA). It will become clear in the following discussion, that there were some aspects of narrative analysis that I struggled with and I developed a form of TNA that fitted with my research philosophy and aims. Before discussing my approach in detail, I will discuss transcription, which I will argue is the first stage of the analytical process.

3.5.1 Transcription

All of my research interviews were recorded using an audio recorder and subsequently transcribed in full, or selectively in a few cases⁸. Transcription is an interpretive process (Denzin, 1995; Lapadat and Lindsay, 1999; Reisman, 2008). It is sometimes assumed by researchers that transcriptions produce a clear, unadulterated representation of an interview interaction. Transcriptions, however,

⁸ Some of the transcriptions were done by a secretarial service who had a professional duty to keep the data confidential. I chose to have some transcribed professionally and to selectively transcribe others due to health reasons that restricted my ability to type at that time. I checked and amended the professional transcripts for accuracy.

are affected by the researcher's theory and methodology. Lapadat and Lindsey (1999) propose that transcription is 'theory laden'. The choices made by a researcher about transcription 'enact the theories they hold and constrain the interpretations they can draw from their data' (64).

The transcription method I chose was informed by how I planned to use the data. Analytical methods that focus on the intricacies of language, such as content or discourse analysis, require a precise representation of the words, intonations, pitch, accent and pauses contained in the dialogue between the interviewer and interviewee (Lapadat and Lindsay, 1999: 68). Lapadat and Lindsay suggest that the researcher's chief concern should not be to attempt to 'represent everything exhaustively in the text but to 'selectively reduce the data in a way that preserves the possibility of different analyses and interpretation' (69).

While using standardised methods for transcription may enable further analysis of data by other parties it must be acknowledged that, 'language, meaning and processes . . . are situated in time and place and always negotiated or emergent' (Lapadat and Lindsay, 1999: 70). Research interactions are embedded in macro-contexts (wider societal structures) and micro-contexts (the immediate context of the research interview). Interview discourses are 'constructed dialogically through the contextually informed moment-by-moment choices of participants' (Ibid: 73). Gumperz and Berenz (1993) suggest that the situated nature of research interactions can be explored through 'contextualisation analysis'. This involves recording on paper

‘those perceptual cues that participants use in processing ongoing conversation’ (Lapadat and Lindsay, 1999: 70). This would undoubtedly be challenging for the researcher as they seek to engage with and be present with the participant, while also noting down aspects of their behaviour and language, what might be going on in the research environment, or with the researcher her/himself, which may be significant for further analysis.

The dialogues constructed in research interviews must also be examined in terms of both the participant’s and researcher’s social intentions. Edwards (1991) has proposed that talk is both *indexical*, it is situated, and it is *rhetorical*, it is organised argumentatively. Talk, ‘makes available a range of implications and inferences concerning the speaker’s interests, knowledge, thoughts and feelings, [and] efforts at accomplishing particular social actions’ (Edwards, 1991: 525). Research participants respond to such indexical factors and organise their conversation to implement social actions and to persuade. Denzin (1995) goes further in suggesting that the self creates and re-creates itself in the process of discourse:

In speaking I hear myself being created. I hear myself, not as the other hears me (or sees me), but as I want them to hear me . . . My voice creates the public context for my articulated thought (11).

Mishler (1990) builds on the idea of the rhetorical function of talk and places particular emphasis on how the wider societal context influences the construction of talk. He says that transcripts are constructions of ‘different worlds’, depending on our theoretical assumptions. Transcriptions also function rhetorically within their

political and ideological context. Considering the contextual nature of interviews, Kvale (1996) believes that transcriptions are 'an impoverished basis for interpretation' (197). He suggests that translating oral discourse into written text in a technical, unreflective manner does not communicate the subtleties of the interview dynamic. What results is, 'hybrid, artificial constructs that are adequate to neither the lived oral conversation nor the formal style of written texts' (166).

Poland (1995) proposes that irrespective of their technical proficiency, transcripts are open to a multitude of interpretations depending on the positionality of the reader. Positionality can be thought of as,

The poststructural, postmodern argument that texts, any text, are always partial and incomplete; socially, culturally, historically, racially, and sexually located; and can therefore never represent any truth except those truths that exhibit the same characteristics (Lincoln, 1995: 280).

Denzin (1995) suggests that the emphasis placed on producing technically competent transcriptions is underpinned by modernistic, positivist assumptions, in a belief that presumes there is 'a stable social reality that can be recorded by a stable, objective scientific observer' (1995: 7).

With the question, 'what is a useful transcription for my research purposes?' Kvale (1996) proposes a pragmatic approach to transcription (166). For ethical reasons, my transcriptions will not be available for analysis by other researchers and so they will not be subject to an alternative form of analysis. I was therefore able to adapt a style

of transcription that fitted my research purposes, allowing me to focus on the content of the data. In thematic narrative analysis (TNA) language is a 'resource, rather than a topic of inquiry' (ibid: 59). Williams (1984) and Ewick and Silbey (2003), who take a TNA approach, "clean up" the dialogue to make it more readable. Riessman sums up this approach:

Speech quoted from interviews is "cleaned up" to some degree, for his texts erase dysfluencies, break-offs, interviewer utterances, and other common features of interview conversations (Reissman, 2008: 57, 58).

In TNA emphasis is on the "told", the content of the speech, 'the events and cognitions to which language refers' (ibid: 58). Hence, the messiness of language is cleaned up. Following this example, in practice I usually omitted phrases that interrupted the flow of speech and had nothing to add to the content of what was being said (e.g. em, eh, ahum). I included comments about tone of voice when it indicated some level of emotion that elaborated upon the meaning of what was being said. I tried to preserve some of the colloquial pronunciation to illustrate the authenticity of local accents.

3.5.2 Thematic narrative analysis (TNA)

Narrative analysis incorporates a number of possible emphases, the most common of which are content (or meaning), structure (form) and performance (interactional and contextual) (Mishler, 1995; Lieblich et al., 1998; see Ch. 3.4.2 for an explanation of narrative). Thematic narrative analysis focuses on the content of data. It is distinct

from other forms of thematic analysis in that it aims to keep individuals' stories intact by 'theorizing from the case rather than form[ing] component themes (categories) across cases' (Riessman, 2008: 53). Riessman (2008) uses four exemplar studies to illustrate thematic narrative analysis: Williams (1984); Cain (1991); Ewick and Sibley (2003); and Tamboukou (2003). On the basis of her examination of these four studies, Riessman (2008) draws four conclusions about the nature of TNA. Firstly, each example starts with a guiding theory, while allowing space for new theoretical insights to emerge. Secondly, the 'story' is kept intact, through preserving sequences and retaining narrative detail, 'rather than thematically coding segments' (74). Thirdly, narrative accounts are commonly historicised, taking the influence of time and place into consideration. Finally, TNA is 'case centred', rather than theorising across cases.

Thematic narrative analysis is approached differently by different researchers. There are differences in how a unit of narrative is defined, or how to define the boundaries of stories. Williams (1984), for example, understands narrative as a person's whole biography, in his interviews, this consisted of all of the talk about chronic illness. Ewick and Silbey (2003), in contrast, see the story as the brief segments of interview texts that are concerned with their topic of interest, 'stories of resistance to legal authority' (1338). Narratives are also represented differently according to how they are constructed by researchers. Narratives may, for example, be constructed from transcripts of interviews, from memories of fieldwork or from written documents such as letters.

Of the studies that Riessman (2008) overviews, Williams' (1984) study is methodologically closest to my own in that he constructs his narratives from one-to-one interviews with people. The way Williams defines the narrative unit also reflect my own understanding, having an interest in each person's biography, while focusing on particular themes. Williams worked with one interview at a time 'isolating and ordering relevant episodes into a chronological biographical account' (Riessman, 2008: 57). After Williams has (re)constructed his biographies for all his interviews he 'zooms in, identifying the underlying assumptions in each account and naming them' (ibid.). Williams identifies three cases to 'illustrate general patterns – range and variation – and the underlying assumptions of different cases are compared' (ibid.).

Riessman (2008) notes that the exemplars of TNA pay considerable attention to macro-contexts, 'as authors make connections between the life worlds depicted in personal narratives and larger social structures - power relations, hidden inequalities, and historical contingencies' (76). However, she suggests that the studies lack attention to the 'local' context, i.e., the 'audience, where a specific utterance or written narrative appears in a longer account, or the relational dimension that produced it' (ibid.). This omission portrays a neglect of the significant evidence-base on reflexivity in qualitative research, attesting to the co-construction of interview stories in a particular time and place (Etherington, 2008). Practising reflexivity during the analytical process can help the researcher to take into account of how local context and social interactions might impact the construction of the interview discourse (Finlay, 2003).

3.5.3 Adapting TNA

Thematic narrative analysis, as discussed by Riessman (2008), was the starting point for the analysis of my data. In practice, I developed my own version of TNA which adapted some of the principles suggested by Riessman. I faced two main obstacles in following orthodox TNA; one was epistemological, the other ethical.

When I first started to explore TNA, I found particular inspiration in Etherington's research investigating drug misuse, trauma and identity (2006, 2008). I was drawn to the way she examined individual's whole stories in-depth using a combination of her own summaries and reflections, and direct quotations from her participants. I also drew inspiration from McCormack's (2004) method of 'storying stories'. McCormack used his interview transcripts to construct an interpretive story, in consultation with his interviewees, which he ordered in a conventional fashion, with a beginning, middle and end.

Following Etherington and McCormack I started to re-story the stories that my participants shared in our conversations. I found this to be a helpful process in understanding my participants' biographies. The accounts that they shared were often disjointed and unsequential, sometimes jumping from one time period to another, often omitting significant details. The process of re-storying helped me to organise events chronologically and see how different people, experiences and services played a part at a particular time. It was sometimes unclear how long a time period lasted for or how the periods fitted together. Creating a chronological story

helped to clarify timeframes. The process also allowed me to identify missing information.

I had also thought that I would send the stories I produced back to each respective person, following Etherington's (2008) practice, and inspired by what I had read about participatory research (e.g. McNicoll, 1999). My reasoning was that this would be more ethical because it would allow my participants to correct any errors I had made or add any important missing details to their story. This, I thought, would contribute to the validity of the story.

Once I had drafted the first story, I sent it back to the participant. I thought I would meet with the person to get their feedback on the story. I met with the person to review their story but found that they had very little to say about it. The person had an issue with one word I had used, which I corrected. Otherwise they repeated much of what she had told me already. After we had looked at the document together I took the opportunity to explain what would happen next in the research process. I also asked them if they had any feedback about the process so far. Again they didn't have much to say. I was hoping that they would tell me that being involved had been therapeutic and reading the story I had produced had been encouraging – this however did not happen. They said that much of what the story recounted was distant to them now. They felt like a different person. However, they did express that they were glad to be able to share their story, not for their own benefit, but for the benefit of those who might read it. It seemed that, at least in this case, having a follow

up meeting was not particularly productive or helpful for either the participant or myself. Considering the time and effort required to arrange such a meeting I began to question its value. I decided not to arrange any further follow up meetings, concluding that they would not necessarily bring me any closer to the 'truth' of their experience and that such meetings may well add more complexity to the data, rather than clarity.

I continued to re-story a number of the participants' stories but eventually realised that large parts of the interview data did not easily fit within a narrative framework. Some parts of the accounts consisted of the participants reflecting back on past experiences or sharing their reasons for their actions or beliefs (Tilly, 2006). In experimenting with the re-storying approach I also began to see an incongruence between my epistemological view and the method. By trying to compose a neat, comprehensive story of individuals' recovery experiences felt I was falling into a realist trap (Hinchman and Hinchman, 1997), suggesting that what I had produced was *their story*, a true account of their lived experience. As I pondered this issue I began to realise that my method had neglected the dialogical nature of the interview. Rather than seeing the person's story of recovery as the only story contained within our conversation, I started to see our conversation as a story which we constructed together.

My approach to analysis became pragmatic, using methods that helped me to meet my research aims. I maintained some of the key principles of TNA as suggested by

Riessman (2008): focusing on content, determining themes, having a guiding theory (i.e. personal belief systems) and historicising narrative accounts. I discovered that trying to keep individual stories intact led me into realist assumptions. However, by presenting vignettes of participant's experiences of problematic substance use, recovery and belief I have attempted to preserve sequences and retain narrative detail. I felt that this was important to allow the reader to contextualise my discussion of themes and theories within a person's narrative. I also tried to incorporate some discussion of the local context (a lack in TNA according to Riessman) using reflexivity to account for the co-construction of the interview accounts. My method also diverged from TNA in that I theorised across cases as well from individual cases. I believe both approaches are epistemologically valid for an exploratory study. The following list summarises the techniques that I used in my analysis:

- Transcribing / checking transcriptions for accuracy
 - Listening / re-listening
 - Thematic mapping (problematic substance use and recovery)
- Indexing transcript content by page
- Reflective writing on key themes (problematic substance use, Recovery, belief)
- Re-storying
- Writing vignettes summarising problematic substance use, recovery and belief
- Coding in NVIVO
 - Exploration (e.g. by word search) and Identification of common themes
 - Grouping of themes
 - Organising quotes by theme
- Summarising characteristics of participants in Microsoft Excel

The processes of transcribing, listening and re-listening to the interviews helped me to become immersed in the data. As an early step in determining themes, I used a technique of thematic mapping while listening to the interviews (see appendix 12.8 for examples). I also indexed interview content by transcript page number to aid my analysis. Writing reflectively on the main themes, re-storying and writing vignettes helping me to further familiarise myself with the data and think about how elements of their accounts related to each other. I developed themes further using NVIVO software. This helped me to explore themes more thoroughly and organise them more effectively. It also helped me to organise quotations by theme. I used Excel software to plot an overview of each participant's key characteristics such as demographics, substances used and types of belief ascribed to. Using a narrative lens in my analysis was helpful in allowing me to see the various level of stories present in my participants' accounts (e.g. the story of the interview; the stories within my participants' accounts; the story of my PhD; the meta-narratives that individual use to make sense of their stories).

3.6 Ethics

The research process can be thought of as an inherently moral and ethical enterprise (Kvale, 1996; BSA, 2002; Butler, 2002). As a social work student at the *University of Edinburgh*, funded by the *Economic and Social Research Council* (ESRC), I am bound by the *School of Social and Political Science's* and ESRC's ethical framework (University of Edinburgh, 2011; ESRC, 2010). Besides my institutional duty to conduct ethical research, I feel a personal moral responsibility to be ethical in conducting

research. There is a number of general ethical issues that I have tried to consider in conducting this research. These include consent, confidentiality and communication support (Kvale, 1996; Christian, 2005). In addition to these, there have been specific ethical issues to consider related to the potential sensitivity of discussing problematic substance use and beliefs. I will discuss the ethics of my research under the following headings: information and communication needs; confidentiality and consent; data usage; ethical issues related to problematic substance use; ethical issues related to beliefs; therapeutic effect, boundaries and emotions; and managing interpretative power. I will reflect on the ethical elements of my research experience throughout.

Information and communication needs

Before conducting interviews with participants, I ensured that they had sufficient information about the project so that they could make an informed decision about whether or not they wanted to be involved. I used an information sheet and consent form to aid this process (appendices 12.3 and 12.5). After initial contact (in person, by phone or email), I sent them a copy of the documents to read. The information sheet highlighted who I was and who I represented and it gave details about the nature of the interview, including the fact that it would be recorded. The information sheet also highlighted that participation would be voluntary and confidential and it gave details for making a complaint if required. The consent form highlighted the voluntary nature of the process (e.g. they could withdraw at any time), confidentiality and data handling. Once they had received the documents I contact them again to confirm that they understood what was involved in the research process. If they were

still happy we arranged a time and place to meet. Again, when meeting for the interview, I asked them if they were clear about what was involved and asked them if they had any questions. I also explained the consent form and asked them to read and, if they agreed, to sign it. I gave them a copy of the form for their records. I was aware that not all participants may have had a high degree of literacy or may have had other communication needs, such as English as a second language or impaired sight or hearing. My plan was to ask participants about their communication needs and make adjustments if needed (e.g. reading out literature, arranging for an interpreter or signer to be involved). However, I did not always do this systematically, sometimes forgetting to ask on first contact. It transpired that all of my participants had a good degree of literacy and no other communication needs were evident.

Confidentiality and consent

All participants were asked to read and sign a consent form (appendix 12.5). It states that any information that participants share will not identify them by name in any research reports. My sample is a small group of people, associated with a small subculture (the recovery community), in a relatively small geographical area (central Scotland). To maintain the confidentiality of my sample, as well as using pseudonyms, I have had to be careful about not disclosing other details that might identify them. This has included anonymising any specific agencies or groups that they were involved in, the exception being large multi-branch organisations like AA. I also anonymised locations. The details of a person's recovery narrative could also potentially identify them. Portraying the details of my participants' recovery

narratives is central to this report, but to facilitate confidentiality I have tried to withhold potentially identifiable elements where possible.

The consent form also states that no information identifying participants will be shared with outside parties, except when they disclose their intention to harm themselves, someone else, or that they are at risk of being harmed by someone else. I was aware that some of the participants might disclose past criminal activities, including the current use of illegal substances. I tried to make it clear that past criminal activities would not be disclosed unless they posed an imminent threat to themselves or someone else. I was also conscious that some participants might have had learning difficulties or mental health problems that could hinder their ability to give informed consent (e.g. substance-related cognitive impairment). Initially I thought that I could ask them about this before arranging an interview, to give them the opportunity to discuss support from a guardian or mental health worker. This would have allowed me to gain consent in consultation with the participant's support person and, if requested, their guardian or worker would be able to accompany them to the interview. I discerned that it was unethical to bring up the topic when communicating by phone or email. I decided that it would be best to draw on my professional judgement on meeting the person to discern if there might be an issue. Based on my judgement, all of my participants had the cognitive and mental capacity to give informed consent.

Data usage

My information sheet (appendix 12.3) states that research data will be kept securely and elements of the data will be used to compile a PhD and may contribute to presentations and other publications. While postgraduate students are exempt from the requirement to submit their research data to the *Economic and Social Data Service*, they are encouraged to do so to strengthen the resources available to researchers. However, the confidentiality of my participants is my primary concern. Considering the potential sensitivity of the interview data, data will be disposed of after analysis. I aim to destroy audio files, digital transcripts and notes 2 years after completion of the PhD.

Ethical issues related to problematic substance use

My participants talked about their historical experiences of problematic substance use as they discussed their recovery. It was possible that this discussion could cause psychological distress or discomfort. A lifestyle of problematic substance use is associated with relationship breakdowns, unemployment, financial crisis, homelessness, crime and ill health (Scottish Government, 2008b; 2009). It was likely that feelings of deep emotion, guilt, shame, anger and resentment would be unearthed in the interviews (O'Connor et al., 1994). It would be unethical to coerce someone to talk about personal issues that may be deeply emotional and potentially traumatic. To tackle this issue, I made it clear to my participants that it was up to them what they shared and what they kept to themselves. I did this at the beginning of the interview when discussing the information sheet and consent form. Also, when

it became evident that our discussion was touching on a sensitive or emotive topic, I emphasised this point. I planned to offer interviewees the options of moving on to another subject or stopping the interview if they appeared to be experiencing emotional distress. There was also the possibility that some participants may have relapsed as a result of their involvement in the project. As a precautionary measure, for those who may have been impacted negatively, either during the interviews or subsequently, I offered an information leaflet detailing services they can access for therapeutic support (including mental health support, addiction counselling service and religious pastoral support).

Ethical issues related to beliefs

There are additional potential ethical pitfalls in interviewing people about beliefs. Religion and spirituality can, for some people, be associated with emotionally sensitive issues such as religious abuse, existential angst, bereavement or mortality (Culliford and Eagger, 2010). As someone who has religious and spiritual beliefs and values I may be tempted to allow my views to affect the discourse or be tempted to take on the role of 'spiritual director' (Furness and Gilligan, 2010; Hodge, 2001) or even evangelist. Or, I may be tempted to stand in judgement on someone who has different beliefs. I believe maintaining professional boundaries (see following) and being reflexive (Ch. 3.1) about my thoughts and feelings within the research experiences will help me to be aware of these possible obstacles and avoid pitfalls.

Therapeutic effect, boundaries and emotions

It has been argued that the research interview can perform the role of a therapeutic experience for research participants (Kvale, 1996; Birch and Miller, 2000; Bondi, 2003). I believe my research had therapeutic potential for my participants. This raised the ethical issue of relational boundaries between researcher and participant. As a previous project worker, familiar with support assessments and therapeutic dialogues, there was a risk that I may have confused my new role as a researcher with my previous role. By stating my academic status and research objectives clearly, I hoped that my participants would perceive me as a researcher rather than a support worker or therapist. In addition, I hope the way I responded to their support needs made my role clear to them. This is not to say that the researcher/participant relationship should be cold and emotionless. Goodrum and Keys (2007) suggest that it would be unethical not to respond supportively to an interviewee who is experiencing emotional distress. As a researcher this involves empathetic listening. Giving my participants an information leaflet, for follow-up therapeutic support, hopefully emphasised that my role was not therapeutic, while also expressing that I cared about their needs.

As well as taking account of participants' emotions, I tried not to deny the place of my own emotions. It would be selfish for me to allow myself to become too emotionally involved with my participants' stories, yet it would be unethical to be emotionally cold. Goodrum and Keys (2007) suggest a balance of emotional detachment and compassion aided by reflexive journaling, debriefing and unwinding

after emotionally intense sessions. I was also aware that I was open to experiencing psychological distress in listening to stories related to problematic substance use (e.g. drug overdoses, violent crime, deaths). Even though the focus of my questioning was not on problematic substance use, several participants felt the need to share experience that had been traumatic to them. I tried to make use of my supervisors for the purpose of debriefing, as well as writing reflexively and taking time to unwind. I believe my training in counselling and social care work experience helped me to process their stories. However, whatever coping techniques one adopts, I believe the researcher cannot remain unaffected emotionally. I will not forget some of the tragic stories that were recounted to me.

During my experience of this research I faced a number of emotional incidents. During my first interview my participant became emotional and started to cry when talking about her difficulty in connecting with people. All I felt I could do at this time was listen to her. This meeting emphasised for me the potentially therapeutic nature of the research interview (Birch and Miller, 2000). It seemed that my participant was coming to new conclusions about herself as we spoke. I was careful not to question the participant too deeply at this juncture. In subsequent interviews I brought a packet of tissues with me to give to anyone who might cry. I thought this could be a practical gesture of concern. They proved to be helpful in a couple of cases.

Managing interpretative power

An ethical issue that relates to the narrative method concerns the interpretation of interview data. Chase (1996) urges, that when using the narrative method, we pay special attention to participants' vulnerability and analyst's interpretative authority. She suggests that the story format can leave the interviewee more open to exploitation and she questions how much control the researcher should give to the participant over *their* story. Chase is eager to challenge hierarchical relationships and exploitation through feminist principles. It has been proposed that part of balancing the inequalities of power may be sharing the interview transcript or some of the interpretation (e.g. Etherington, 2008). I experimented with sharing some of my re-storied accounts with a couple of participants. This seemed to do little to affect any imbalances of power. While I have attempted to represent my research data in a way that is respectful to my participants, I have come to terms with the fact that because this is *my* PhD, I hold the power of what is produced. Allowing participants to 'check' the transcripts or interpretations could be seen as a superficial gesture that conceals the true imbalance of power, as Chase (1996) suggests:

Sharing work in progress with participants does not necessarily lead to agreement on how interpretations should be made, what is sociologically significant, and what should be published. The researcher must decide how to respond to, negotiate, or present disagreement, and in doing so, she continues to exercise control over the research process (50-51).

Chase (1996) puts forward three concluding suggestions: firstly, the interviewer has an ethical responsibility to inform the interviewee that their story will be reframed 'through connections to the broader cultural context'; secondly, the

interviewer should offer the interviewee the opportunity to have parts of their story changed or removed for the purpose of confidentiality, and this agreement should be honoured; thirdly, interviewees need to be informed that we cannot tell them in advance if their story will be used or what conclusions will be drawn from their stories (56-57). And ultimately we need to acknowledge to our participants that we, as the researchers, claim the final authority over the interpretation process. We also need to acknowledge that research interviews have the potential to cause harm and do all we can to take preventative measures:

The problem is that, once the researcher's account is taken as the authoritative interpretation of an individual's experience, the individual's own understanding of their experience inevitably is compromised. Narrative research in this way can become intrusive and subtly damaging, even when participants respond positively to the researcher's account (Smythe and Murray, 2005: 178, 179).

I hope that the way that I have framed my analysis of the research data will diminish any potential harm. I have made it clear that the stories that I have re-presented and my analysis is *my* interpretation – it is not meant to be a reflection of the truth of my participant's experiences of recovery. My analysis is a fragmented picture of encounters that have been co-constructed between myself and my participants in a particular time and place (Riessman, 2008).

3.7 Quality and limitations

A range of labels has been used to define the quality of research – validity, reliability, replicability, transferability, confirmability, trustworthiness, credibility, truthfulness,

authenticity, applicability, consistency, neutrality and relevance (Lincoln and Guba, 1985; Hammersley; 1992; Seale, 1999, 2002). The search for 'truth' has been perhaps the main goal of modern positivist scientific research. Claims of truthfulness, validity and reliability have been contested by postmodern thought in social science research. Seale (1999) posits that the 'modernist' terms of validity and reliability are inadequate in the context of postmodern thought and we must acknowledge that 'quality' is a 'somewhat elusive phenomenon that cannot be pre-specified by methodological rules' (7).

Denzin (1988), an advocate of postmodern epistemology, suggests that by trying to make qualitative research scientifically respectable, 'researchers may be imposing schemes of interpretation on the social world that simply do not fit that world as it is constructed and lived by interacting individuals' (432). He says there is a conflict between scientific aims, and preferences to embrace subjective and interpretative approaches. In the face of this 'representational crisis' and anxiety about the 'nihilistic tendencies of postmodernism', some researchers, especially in practical disciplines like social work, have turned to 'advocacy of ethical and political goals as replacements for truth value' (Seale, 1999: 2; 2002: 101).

If it is accepted that reality is socially constructed and 'knowledge [is] situated and created within contexts and embedded within historical, cultural stories, beliefs, and practices', then positivist rules for discerning what is true do not easily apply (Etherington, 2007: 599). Mishler (1990) proposed that the validity or quality of any

piece of research cannot be assessed universally by abstract rules or procedures, but 'on the whole range of linguistic practices, social norms and contexts, assumptions and traditions that the rules had been designed to eliminate' (418).

In my discussion of sampling theory (Ch. 3.3), I raised the problem of generalising from a small number of cases and the practical benefit of my research. This issue is addressed by Riessman (2008) as she considers the pragmatic use of narrative-focused case-centred inquiry. She draws chiefly on Flyvbjerg's (2006) discussion of the misunderstandings about and the benefits of case-studies. Flyvbjerg highlights the advantage of the case-studies methods in the following five key points. Firstly, case-studies produce context-dependent knowledge which is invaluable for human learning (e.g. in social work training). Such knowledge provides a 'nuanced view of reality' (2006: 6). Flyvbjerg goes as far as to suggest that, in the social sciences, predicative, general, context-independent theory is essentially unachievable. Secondly, the history of science has shown that single cases, accompanied by critical reflexivity, can be instrumental in the development of knowledge. Flyvbjerg highlights Galileo's rejection of Aristotle's law of gravity. He uses this, along with other examples, to conclude that it is possible to generalise from a single case, 'as supplement or alternative to other methods' (12). Flyvbjerg's use of the term *generalise* in this context applies to falsification testing, rather than what he calls 'formal generalisation', meaning 'predictive theories and universals' (12, 7). Thirdly, case studies can be useful for investigating atypical, extreme or paradigmatic cases (e.g. Geertz' deep play of the Balinese cockfight). Fourthly, despite accusations of a

higher degree of subjective bias, case studies 'contain no greater bias towards verification of the researcher's preconceived notions than other methods of inquiry' (21). Case studies provide the opportunity to "close in' on real life situations and test views directly in relation to phenomena as they unfold in practice' (19). Because of this, they are more likely to produce falsification of hypotheses. Fifthly, case studies can provide thick narrative detail that reveals the diversity, complexity and sometimes conflicting stories of actors.

While narrative-focused case studies have many benefits, their limitations must also be acknowledged. The intensive work involved in producing narrative-focused case studies limits the number of cases that can be produced in any one project. In addition, the accounts that emerged in my research were co-constructed between myself (the researcher) and my research participants, and so were affected by numerous factors, including: time, place, personality, positionality, my research agenda, the set research questions, the participant's agenda, memory, imagination and emotion (Miller, 2000; Finlay, 2003; Freeman, 2006). In this regard, the accounts do not equate to the 'truth' of the individual's experiences or views (if such an ideal were attainable). The accounts therefore provide only a veiled insight (as through gossamer walls: Doucet, 2008) into the lived experiences and thought processes of my participants. My re-presentation of these accounts in this thesis may, in one sense, distance the reader from the raw data of the interviews. However, I trust that my discussion, emerging from my in-depth study of the data, will help the reader to

better understand what has been significant to my participants in their experiences of recovery and journeys of belief.

Riessman (2008) suggests that transparency can be a measure of validity and trustworthiness in research. I believe that transparency, is one of the key measures of the quality of my research. According to Riessman, this may involve being explicit about methodological decisions, describing how interpretations were made, acknowledging alternative interpretations and making primary data available if appropriate. Transparency is something I have tried to practise, in being clear about my methodology and my interpretative assumptions. This has been facilitated through employing critical reflexivity in my writing (see Ch. 3.1). While I have tried to provide much of the original interview data in quotes and narrative summaries, ethical and pragmatic considerations, led me to withhold the complete transcripts.

In chapter four, I will observe that beliefs, as they are related to recovery, are best understood within the context of broader factors (processes, resources, trajectories) involved in recovery. The boundaries of this project have meant that I have been able only to provide pictures of my participant's experiences of recovery (as they presented them, and as I interpreted them) in rough outline. I have presented some indication of the trajectories involved in their recovery pathways, the processes involved in their recovery and the resources that facilitated their recovery. Much more could be learned about recovery and belief with further investigation into some of the aspects of recovery that proved to be important to my participants (e.g. the

role of family intervention; the impact of different types of professional treatment; the benefits of recreational activity in recovery). Also, considering the effect of variations such as gender, sexuality and types of drug used are highly relevant. In the end, I had to choose to focus on what was central to my original interests and attainable within the boundaries of my research methodology, timeframe and word-count.

The original aim of my research was to shed some light on the role of beliefs in individuals' experiences of recovery in Scotland. I believe that this project achieves this, at least in part. The application of my research data is limited by the size and characteristics of the sample (i.e. geographical locations, ethnicity, drugs used; severity of drug use; length of recovery etc.), and the limitations of my methodology and my subjective interpretations. However, I believe the quality of my research resides in the in-depth qualitative data that was produced through my interviews and that I have presented in detail in my analysis. The quality of the project has also been strengthened through being critically reflexive, transparent and ethical in my approach. These processes have been reinforced through dialogue with my supervisors.

4 Contextualising beliefs in recovery pathways

The aim of this project is to explore beliefs in pathways of recovery from problematic substance use. This aim is posed in the question: ‘What role do beliefs play in individuals’ experiences of recovery?’ While there may be various ways to answer this question, I will approach it by addressing the following three questions: ‘How do individuals construct beliefs in recovery?’, ‘How do individuals practise beliefs in recovery?’, and ‘How do individuals integrate beliefs in recovery?’ In this chapter, I will present each participant in turn as a means of introducing the participants’ ‘stories’ and to illustrate the range of recovery pathways and beliefs represented. This chapter will function as the foundation for the subsequent chapters in which I will address the three research questions directly.

Following a narrative method (Riessman, 2008), in this chapter I provide vignettes which function as an overview of each person’s experience. The vignettes are divided in two parts: problematic substance use and recovery. After each vignette I reflect on the person’s beliefs in terms of how they presented them and how they saw them relate to their recovery. The vignettes provide some basic narrative detail in which to contextualise and make sense of my subsequent discussion of beliefs. As I have already discussed, the stories that I present do not represent the ‘truth’ of my participant’s experiences of problematic substance use and recovery. They are stories that I have constructed, gathering together elements from my interviews, which

were, in turn, co-constructed between myself and my participants. Memory, imagination, relational and contextual factors in different ways limited and constrained the accounts that were shared. My own personality, agenda and bias have undoubtedly influenced how I told their stories. The varying lengths of the vignettes and variations in the amount of detail included is largely an indication of the varying detail that each participant shared with me. Some participants provided large amounts of detail that I have not been able to include due to the practical limitations of this thesis. In addition, I have withheld some sensitive details to preserve participant confidentiality. Despite these limitations, I have tried my best to portray my participant's stories with honesty and respect. Where possible, I have tried to illustrate the vignettes with the participant's own words (in quotation marks).

While I have delineated problematic substance use and recovery in the vignettes, it is not always easy to make such simple distinctions. Recovery is a process that is rooted in experiences that happen during periods of problematic substance use. People often make numerous attempts to recover, and these experiences may have an accumulative effect, enabling long-term recovery. The beginning of a recovery journey is therefore difficult to define. However, many participants did have significant turning points in their recovery journey, which, for some, marked the beginning of their long-term recovery. In most cases, recovery was equated with abstinence, or in one case, becoming stable on a substitute prescription (eventually leading to abstinence). I have used these turning points to mark the beginning of the recovery stories. I have ended each recovery story with the length of time that they

had been in recovery when I interviewed them. This is meant to give a general indication of the maturity of their recovery experience and should not be taken too literally. This is because, it is not always clear when recovery starts and when it ends (i.e. when is a person recovered?). For some, recovery is on-going, while for others it is a past experience.

4.1 Jo

Problematic substance use

Jo is a 59 year-old female who had a problem with alcohol. Drinking alcohol was part of her family culture and when she got married she drank every weekend with her husband. Alcohol started to become a serious problem for Jo when things started to go wrong in her marriage. She started to drink on a daily basis. She believed that drink 'had her' at this point in her life. When she separated from her husband she knew she had to stop drinking and she managed to do this on her own. At this point in her life she abstained from alcohol for seven years. On a whim Jo started to drink again. She started drinking a bottle of wine each night and soon was drinking a box of wine most nights. At this time, she was working in a stressful job where heavy drinking was part of the social culture. This pattern of drinking continued for eight years.

Recovery

Jo was encouraged to rethink her drinking patterns when she became the victim of a violent assault, by someone who was drunk. The trauma of this experience spurred her to cut down her drinking. During this period, she substituted alcohol for cannabis.

After about four years, prompted by the deterioration of her relationship with her partner, she got involved in Alcoholics Anonymous (AA). Jo believed that her recovery started properly when she started to go to AA. AA helped her to be honest and to get to know herself. Jo's spirituality also became an important aspect of her on-going recovery, particularly singing in the church choir, and singing Mass and praying to God in private. Jo had been in recovery for eleven years.

Beliefs

Jo described her beliefs as both Roman Catholic and 'catholic in the true sense'. While she loved Roman Catholic High Mass, and found it rewarding, she saw goodness and truth in all beliefs and was happy to 'take a wee bit from anybody's'. She explained that she knew a Buddhist, and Jo thought that there's a lot in Buddhism that's 'fab'. The following statement sums up what she thought about the presence of goodness in the world and her understanding of God:

I'm quite happy with God, higher power, spirit of the universe, you know, spirit of the trees, and the woods, and whatever, that's alright, but there's . . . but I think there's a goodness. I think there's a power for good. (Jo)

When I asked Jo more about her beliefs she clarified that she identified with the spiritual side of Christianity rather than what she called the 'religious thing'. Jo was put off by what she perceived as 'worshipping the church' and some people's special treatment of the clergy. She identifies more with the philosophy of 'do as you would be done by' and 'be nice to people'. Jo also identifies her spirituality with Jesus fighting against the religious hierarchy. Jo's spiritual practices were very important to

her in her recovery. Even while she would go through long periods of not attending Mass, when she got sober after going to AA, she rewarded herself through auditioning for the church choir. For Jo, singing in the choir connected her with positive experiences in her childhood and it helped her to feel better about herself.

4.2 Nina

Problematic substance use

Nina is a 50 year-old female who had a problem with alcohol. Nina's problem with alcohol developed gradually over the years. She used alcohol as a 'crutch' to deal with her challenging life circumstances – a difficult family background, abusive partners and depression. Nina came to the point where she was drinking four bottles of wine and ½ bottle of vodka on a daily basis. She also dabbled with cocaine but alcohol was her primary obsession. As a result of her alcohol use, Nina lost her ability to hold down a job and her relationships with her children deteriorated. Her heavy alcohol use led her to being admitted to hospital with acid reflux and pancreatitis, from which she nearly died.

Recovery

Shortly after Nina's diagnosis of pancreatitis, she sought help through her general practitioner (GP). With support from her GP and her husband, she detoxed in her home. She then got involved in a local addictions centre where she was assigned a counsellor, attended an introductory recovery group and then a SMART recovery

group. After attending the SMART group for four months she was supported in her recovery by a community-based addictions worker.

Eight months after her detox, Nina found her Christian faith again and got involved in a local Church of Scotland. Connecting with the church, especially through baking bread for communion and helping with social initiatives was very important to Nina. Other activities including cooking and dog walking also became an important part of her new life. She learned to enjoy life again, accept herself and find her 'real' self. Nina had been in recovery for two years.

Beliefs

The initial phase of Nina's recovery was essentially secular. She detoxed from alcohol and cocaine with the support of her GP and husband. After this she got linked in with a two phase group work programme which took a 'scientific' cognitive behavioural approach. As Nina started to rebuild her life she developed habits that gave structure and purpose to her life (cooking, baking, dog walking). Nina had a long-term Christian faith but during her period of problematic substance use she did not attend church because she was ashamed of her lifestyle. However, she still had a sense of God being with her. Eight months after her detox her faith was revived, in her words, she 'embraced God again'. Getting involved in her local Church of Scotland reinforced her sense of worth and helped her to rebuild her identity. While she was adamant that she was responsible for her own recovery, her faith in God's love enabled her to believe that she could get better and helped her to see the positive in her recovery.

Serving the church through bread making became an important spiritual practice that connected her to the community and reinforced her self-worth.

4.3 Sean

Problematic substance use

Sean is a 39 year-old man. Sean's primary problem drug was alcohol but cannabis, amphetamines, LSD and cocaine also played a role in his problematic substance use. During his early to mid-teens, Sean experimented with LSD and shortly afterwards started to drink alcohol. Sean often had blackouts and was frequently detained by the police for being drunk and disorderly. He started to use cannabis regularly at 18 years old and drank on the weekends until he was 21. During his 20s Sean's drinking became a daily habit, resulting in severe withdrawal symptoms and hallucinations. At this time, he used amphetamines on top of his drinking. On numerous occasions, he was admitted to hospital with drug and alcohol induced psychosis.

When 25 years old, Sean was introduced to Alcoholics Anonymous (AA) in hospital. He attended meetings for 8½ months during which he was abstinent from alcohol, though he was still smoking cannabis. After this period, Sean's mental health deteriorated. He tried to take his life several times. He got caught in a cycle of homelessness and prison. In addition, he had a compulsive gambling problem. At the age of 35, Sean entered a residential treatment centre. He abstained from alcohol for over 13 months but then returned to his previous lifestyle.

Recovery

Sean's life changed dramatically at the age of 38, when he had a near-death experience. He believed that this was a spiritual experience that enabled him to accept that he had the 'illness, of alcoholism and addiction.' Following this experience, Sean committed himself wholeheartedly to the programme and principles of AA. He also got involved in a Christian church and embraced the Christian gospel. With help from an addictions worker and involvement in Alcoholics Anonymous and Cocaine Anonymous, a Christian recovery meeting and a church café, Sean was building a new life for himself. Sean had been in recovery for fifteen months.

Beliefs

Sean's beliefs were influenced by AA and by his involvement in a local Pentecostal Christian church. He talked about having let Jesus Christ into his heart and about having God as his higher power. As well as attending a Twelve Step group that took a Christian perspective, Sean had a structured recovery programme built around his core beliefs:

I'm working on the AA Steps as well. I'm just basically on a programme the day, you know, basically handing all my care over to my higher power in the morning, and say my prayers and do my readings and that, fae AA. I'm doing . . . regular meetings, joined a group, help out and that. (Sean)

Attending Twelve Step groups and Christian meeting, meeting with a sponsor, practising prayer and meditation and taking a regular personal inventory were all significant to Sean in his recovery.

4.4 Bobby

Problematic substance use

Bobby is a 60-year-old man with a previous alcohol problem. Bobby started to drink socially on the weekends in his late teens. From the beginning, he tended to drink more than his peers. Bobby attended university and attained a degree. He then got a job as a scientist. He drank with his peers at work but his drinking gradually started to affect his ability to work. When Bobby was 40, he lost his job and while he got other jobs he was unable to keep them for long because of his heavy alcohol use. Bobby's alcohol habit led to him becoming separated from his wife, estranged from his children and becoming homeless. At one point he broke both of his shoulders due to falling when drunk. He was also diagnosed with liver cirrhosis and told that he didn't have long to live.

Recovery

Soon after being diagnosed with cirrhosis, Bobby's family persuaded him to go to a Christian-based recovery community. Bobby said that his keyworker described him as 'the worst human wreck he'd ever taken in'. Bobby made the most of the programme and the support in the community. He got further support from a number of education and employment services. He also built a good relationship with a local

church and its minister. The support network that Bobby built enabled him to rebuild his life. He now has a successful business, and a good relationship with his wife and family. Bobby had been in recovery for seven years.

Beliefs

Religious belief, practices and community were an important part of Bobby's early recovery, as he engaged with the Christian-recovery programme and attended his local church. Bobby defined himself as a Christian. His main rationale for this was that he had been 'brought up in a Christian-based country'. He also mentioned that his business reflected a Christian work ethic in how he deals with people. Bobby had a sense of there being a God but his conception of God was non-specific. His reference to Shakespeare's phrase, "There's a divinity that shapes our ends. Rough-hew them how we will," suggested this. Bobby rationalised his turning to religion in the early stages of his recovery as a natural response for someone in crisis:

And I think at any time when you really . . . I mean, I was in crisis . . . and anybody like that tends to head to religion for a bit of solace or a bit of . . . you know, religion's the first thing that you, sort of, hang onto, isn't it. (Bobby)

Bobby's religious belief, practices and community supported him through his early recovery. It seemed that his religion diminished over time. Seven years into his recovery the main indication of his religion is attending church occasionally.

4.5 Julia

Problematic substance use

Julia is a 53 year-old woman with an historic problem with alcohol. Julia started to drink alcohol when she was around 15 years old. She believes that her drinking problem started with her first drink. Julia had periods of heavy drinking and periods of abstinence during her late teens and twenties. Her drinking became more intense when she moved to a city overseas at the age of 30. At this time, she lost jobs, her condo and friendships because of her drinking. At 34 she was told that her liver was quickly deteriorating. When she returned to Scotland a couple of years later her heavy drinking continued to cause her problems. She built up hundreds of pounds of rent arrears and her relationship with her family became strained. Her mental health also deteriorated. She often thought of taking her life.

Recovery

Julia's lifestyle started to change for the better when she was 38 years old. After a particularly heavy binge she decided she had had enough. She got in touch with Alcoholics Anonymous (AA) and started to attend meetings regularly. Through the support of AA and a local recovery community she stopped drinking and built a new life which she enjoys. While Julia says that she is not very religious, she has a faith in a God that has helped her to make sense of her life and recovery. Julia had been in recovery for fifteen years.

Beliefs

Julia did not indicate having any firm existential beliefs at first during our conversation. When I asked her about her belief framework she said that she had 'never really been very religious to be honest.' The main belief that seemed to support her recovery was her belief in AA:

I believe in AA, definitely believe in AA, yeah . . . I definitely believe it is stronger than the illness. If you do what they say it's stronger than the illness. (Julia)

While Julia was not particularly religious, some of her stories and comments suggest that she had some underlying spiritual and perhaps religious beliefs. When she was talking about her period of problematic substance use she said she 'always felt really, really bad . . . not just physically, but I would say mentally as well. Yeah. And I'd say spiritually, too.' She also told a story about an experience with her Roman Catholic grandmother that implied that she had an underlying belief in God. It also became apparent that Julia prayed to God. When she was struggling during a difficult period of problematic substance use she prayed to God, "I'm all on my own . . . you'll really need to help me God." During her recovery she also admitted that she prayed to God every night:

Well I've thanked God every night since I got sober, for keeping me sober. And I've done that for 15 years. Every single night, no matter what's happened, even when I thought I when I thought I was gonna be homeless. (Julia)

While Julia was not strongly religious in practice, and did not have a clear conception of a higher power she had a sense of a God being there for her and a sense of her own spirituality.

4.6 Matt

Problematic substance use

Matt is a 40 year-old man who had a problem with heroin along with other drugs including alcohol, cannabis, methadone, benzodiazepines, amphetamines and cocaine. Matt first drank alcohol when he was 13. At around 17 years old, he started to use cannabis regularly on evenings and weekends. Through his involvement with the dance scene he experimented with acid and speed. By his late teens he was taking methadone, heroin and benzodiazepines on a regular basis. At 20 years old, Matt split up with his girlfriends and his life started to 'crumble' and he went into 'self-destruct' mode. Lying, stealing, turning up late to work and not eating properly were behaviours he associated with his problematic substance use. Matt's father was an alcoholic and it was common for his father to have people around for drinking parties. When his dad started to deal drugs, Matt's life became more complicated. In his mid-twenties Matt carried out a violent assault and was sent to prison for two years. He attended drug awareness groups in prison and was drug-free when he was released. He moved straight into a job but after his girlfriend was killed in an accident he turned to drugs again and lost his job a few months later. Matt's heavy drug use continued into his 30s. Matt got some stability being on a methadone script and in his late 30s

he entered an abstinence-base recovery programme. The programme did not suit Matt. He remained abstinent from drugs for only two weeks after his demission.

Recovery

Life started to really change for Matt when he attended a group work programme for people with drug problems based on a cognitive behavioural approach. Matt took the initiative to change his social network and get involved in healthy activities. Matt's children, mum and auntie have been a source of support and motivation for him. When I interviewed Matt he had been in recovery for six months.

Beliefs

Matt believed in 'backing up theories with evidence'. He was said he 'not religious in any way'. Matt's expressed a belief in naturalism (i.e. only natural laws and forces exist in the world) influenced by his interest in science, archaeology and geology.

I grew up watching science programs on the telly and I love museums, and all that kind of thing, things have got to be explained to me, and show me the evidence of how that works, and then I'll understand it. (Matt)

Despite Matt's strongly secular outlook he admitted that he has had experiences which he described as 'spiritualish'. He still was able to frame these experiences within a secular belief framework.

4.7 Fiona

Problematic substance use

Fiona is a 56 year-old woman who had a problem with alcohol and amphetamines. Fiona started drinking when she was 15 years old. She believed alcohol was a problem from the beginning. At around 19 years old, she started to take amphetamines. She felt like they normalised her. Fiona thought that she drank to cope with the various traumas that she had faced in her life. Fiona's drinking behaviour included experiencing blackouts, getting involved in arguments and being held in police cells for breach of the peace. Fiona's drinking contributed to the breakdown of her marriage and the deterioration of her relationship with her children.

Recovery

Fiona was moved to do something about her substance use when she discovered that her ex-partner had committed suicide. Fiona took steps to get in touch with Alcoholics Anonymous and started to attend their meetings. She was also linked in with group therapy through the NHS. With the help of these resources Fiona's recovery became established. Fiona also made use of person-centred counselling. She has maintained her recovery through involvement in AA and a local recovery community group. Fiona had been in recovery for 13 years.

Beliefs

Fiona described her belief framework as 'spiritual'. Her spirituality was tied up with AA and the concepts of powerlessness and higher power. This is how she explained it:

I think when you go into the [AA meeting] there, they'll say, ken, like, you realise that you're powerless over alcohol, but you also realise you're powerless over your life, and that's why you used alcohol. So I had to believe in something bigger than myself, and I always think, like . . . I would, ken, think, "Well, hold on a minute," and it's like . . . I look at things like plants and I think, "Well, how did it grow?" And this, that and the other, and it's just like . . . all that kind of thing, I says...it's like this hotel's got a manager, I always think that outside's got a manger as well of some sort. And if that's God, then fine . . . I dinnae think God is like a man that I have to . . . I just think it's . . . if I do the right thing, the right thing happens as well, but I do believe that there's a power out there that's bigger than me. (Fiona)

Fiona had a sense of her own powerlessness over her life and over alcohol. She also believed some kind of higher power which she implied was the creative force. Doing the right thing, or moral action, was also part of Fiona's spirituality. She thought that if she did the right thing then circumstances would work out for her benefit. Prayer and helping others were practical part of her beliefs. Prayer was a source of 'inner strength' and helping others reminded her of where she once had been. Fiona had been brought up Roman Catholic but it seemed that she had largely moved on from orthodox Catholic beliefs and practices. She disassociated her spirituality from the 'fear' that she saw in Catholicism.

4.8 Anna

Problematic substance use

Anna is a 46 year-old woman who had historic problems with heroin, alcohol and other drugs (including cannabis, amphetamines and benzodiazepines). Before she was a teenager Anna had drunk wine and sniffed glue, and she soon got into the habit of smoking cannabis. By the time she was 18 years old Anna was a single parent and she had experimented with speed, acid and mushrooms. During her 20s, Anna moved from relationship to relationship, many of which were abusive. Most of Anna's drug use was in her own home. She drank a lot and took speed, benzos and cannabis regularly. While she held down jobs, she struggled with debt and was in the habit of shoplifting to make ends meet. When she was 30 years old, Anna started smoking heroin and also adopted the habit of injecting. Anna's mental health deteriorated during this period. After 16 months of daily heroin use, Anna tried to stop using. She tried to stop many times unsuccessfully over an 11-year period. Anna's heroin use involved blackouts, constant vomiting (when smoking), the loss of her teeth (from stomach acid) and poor self-care. By her mid-thirties, Anna had three children. Anna's relationships with and care of her children suffered as her problematic drug use got worse.

Recovery

Having her third child was a landmark for Anna. It helped her to realise that she needed to do something about her drug use. Also around this time, Anna's first partner died from a drug overdose. Anna felt hopeless and had a sense of despair.

She planned to take her own life but couldn't go through with it when she thought of her youngest child. Instead, she found out about a local Narcotics Anonymous (NA) meeting and went along. This was a turning point in Anna's life. She had a positive initial experience at NA and subsequently went to a structured day detox programme which utilised a Twelve Step approach. Anna attended NA for two years and then attended AA and CA (Cocaine Anonymous). Anna embraced the spirituality of the Twelve Step programmes and also started to explore Christianity after a spiritual experience she had during her early recovery. Prayer and meditation have been important elements of Anna's recovery. Anna had been in recovery for four years.

Beliefs

Anna had a spirituality influenced by the spiritual philosophy and practices of the Twelve Step fellowships she was involved in. She interpreted the kindness of a woman at her first NA meeting as the 'loving and powerful hand of God' – a phrase taken from the AA *Big Book* (Alcoholics Anonymous, 2013). Anna talked about having a number of spiritual experiences, one of which she saw as an intervention from God. This led her to go to a Christian church. The sign outside the church building prompted her to go:

[T]here's a big sign outside that saying, "I am the way, the truth and the life." I've seen it from when I was a wee girl, when I heard that in my bed, when I felt that within my being. I thought, "Oh, that's what it is, God wants me to go to church, that's Gods [sic] calling me." This is my mad thinking. So it took me six months from that night lying in my bed when that happened to go up to the church.
(Anna)

Anna's struggled with the way God was presented in the church but she developed a supportive relationship with the pastor. Anne tried attending different denominations of Christian church including Free Church of Scotland, Roman Catholic and Pentecostal. Anna's religious and spiritual beliefs were, in her words, 'a bit mixed up still.' She believed in Jesus Christ and the Bible but understood that there were many perspectives to Christianity and she didn't know exactly what to believe. Instead, she asked God to help her to get to know him [sic] better. Anna reads a *Recovery Bible* every night which provides a 'recovery' perspective on the Bible, including ideas from Twelve Step philosophy (e.g. Arterburn and Stoop, 1998).

Anna also rooted her spiritual experience in the traditions of AA by linking her spiritual experience with that of Bill Wilson's (one of the founders of AA) in Winchester Cathedral (Alcoholics Anonymous, 2013). Anna talked about being a 'Steps evangelist,' suggesting a similarity between her behaviour and that of a Christian evangelist. Anna was particularly interested in practicing the spiritual principles and traditions of the fellowships: tolerance, kindness, love, understanding and the Prayer of St Francis ⁹ (Alcoholics Anonymous, 1979). Meditation was also an important part of Anna's spirituality. She used it to seek peace and get closer to God. Rather than being influenced directly by Eastern spirituality, it seems that she picked

⁹ 'Lord make me an instrument of thy peace...' - a traditional Christian prayer falsely attributed to St Francis of Assisi, adopted by AA for Step eleven.

up the practice through involvement in the Twelve Step Fellowships and researching meditation on *YouTube*.

4.9 Mark

Problematic substance use

Mark is a 44 year-old male who developed a problem with a range of drugs especially temazepam, heroin and alcohol. During his mid-teens, Mark experimented with inhaling glue and drinking alcohol but temazepam (jellies) quickly became his drug of choice. It was the drug that he 'fell in love with'. Temazepam gave him the confidence he needed, especially as he sought the attention of girls in his teenage years. Influenced by older peers, he soon started to inject temazepam along with heroin. Shoplifting became part of Mark's lifestyle as he needed money to buy drugs. This led him to getting in trouble with the police and being detained in institutions for young offenders. By the time Mark was 16 years old, he was admitted to his first rehab. However, after leaving he continued to use temazepam and heroin. In his early 20s, Mark had had enough of using heroin and went on a methadone script. Mark was on methadone for 17 years. It helped him to stop stealing and it also gave his family some reassurance that he was no longer taking heroin. Mark also got a part-time job. He reflected that at that time he thought he was doing well because he wasn't using heroin. He was, however, buying methadone to use on top of his prescription. Also, when temazepam jellies disappeared from the market he used diazepam, cannabis and alcohol on top of methadone.

Mark turned to using alcohol more and this led him to becoming aggressive and getting into fights. Mark ended up getting arrested and charged for assault and robbery and was imprisoned for three years. In prison, he was able to stay on a methadone script but had to detox from diazepam. While this was happening Mark had a nervous breakdown. While in prison, Mark had the support of his family and he promised them that when he got out he wouldn't return to taking drugs. However, as soon as he got out of prison he immediately went to use diazepam. When he returned to his family home, his mother asked him to leave home for the first time in his life. He defined this as the turning point in his drug-using career. From this point, Mark's lifestyle deteriorated further than it ever had. He was forced to live in homeless accommodation, he returned to stealing and his self-care and health deteriorated.

Recovery

During this period of homelessness, Mark's mother ended up seriously ill in hospital. This had a big emotional impact on Mark. Mark's mother urged him to seek help for his drug problem. He had been involved in treatment services in the past but things were different this time. He was more open to receiving help and 'more desperate'. He was admitted to a rehabilitation centre run by a faith-based organisation and then progressed on to supported accommodation. He also got involved in Narcotics Anonymous (NA) and got linked in with a sponsor. He got involved in voluntary work and eventually got his own tenancy. Mark gave credit to the different professional services who had worked with him along with NA. For Mark it was ultimately having

good people around him that enabled him to succeed in his recovery. Mark had been in recovery for three and a half years.

Beliefs

Mark's belief framework during his recovery seemed to be centred on a belief in people. This is how he summed up his belief framework:

[Its] probably just the people thing for me. You know, the therapeutic value when you sit, and when you share honestly and open with another addict. Because nothing touches it . . . and that's my belief . . . If something happens, for me anyway, when I sit with another recovering addict and just share honestly with them, I get, it's a feeling thing. And I don't really know what that feeling is and I don't really need to know. All I really need to know is it works.
(Mark)

Mark had engaged with a range of types of treatment services (secular, faith-based and spiritual) during his circuitous recovery journey. It seems to have been NA that had the most lasting impact on his beliefs and recovery practices. In particular, the therapeutic peer-support of NA was significant for him. While he didn't feel comfortable with the NA concept of higher power, the NA rituals of prayer and daily readings were important resources for him. These were purely secular practices for Mark.

4.10 Billie

Problematic substance use

Billie is a 47 year-old female who had a long term problem with heroin, combined with a range of other drugs (including alcohol, cannabis, speed, ecstasy, diazepam

and crack cocaine). Billie started to drink alcohol casually during her mid-teens. Around the same time Billie suffered from severe mental ill health and was admitted to a psychiatric ward. This became a regular occurrence over the years. During her late teens Billie started using cannabis, acid and speed on an occasional basis. In her early twenties she got into ecstasy and she 'could not get enough'. She used drugs to deal with the negative emotions she was experiencing at the time. In her twenties she started to drink alcohol heavily and managed to hold down various jobs for short periods. When Billie started to inject heroin, when she was 30 years old, her life became more chaotic. She lost the ability to hold down a job and her two children were taken into care for several months because she was unable to care for them. As Billie's heroin problem took hold, her mental health deteriorated further leading to more frequent admissions to the psychiatric hospital. Billie was prescribed methadone and diazepam but she continued to top-up with heroin. Billie tried to stop using drugs on numerous occasions but she was unable to abstain for long. It was a caring neighbour who first encouraged Billie to get involved in Narcotics Anonymous (NA) when she was around 35 years old. Billie received hope from attending NA and meeting people who were 'clean'. However, throughout the years of attending NA Billie would 'get clean for a wee while and then . . . would pick up again'. When she was 43 years old Billie reached a new low point. She had started using crack, her son was taken into care and she became suicidal.

Recovery

When Billie became suicidal at this time, with support from her daughter, she was admitted to a specialist substance misuse psychiatric ward. Following this she went to an abstinence-based treatment centre for the purpose of detoxing. It also functioned as a stepping stone back into NA. Things were different this time. Billie started to ask for help, develop an understanding of a higher power, become honest and believe in herself. NA and a caring neighbour helped Billie build a new life. The spiritual principles of NA and practising meditation have been at the heart of Billie's recovery. Billie had been in recovery for four years.

Beliefs

Billie identified herself as a 'spiritual person'. Her spirituality evolved through attending NA over several years. This is how she explained her spirituality:

I'm more on the thinking about good and bad energy, positive and negative, that sort of thing, be the best you can be. What you give out is what you get back. I do believe I am not on my own, I believe that I am being looked after. I can't define what it is that's looking after me but I do believe that is a power that loves me, that wants the best for me, and I tap into that to help me through my day to day. That's my belief today, whereas before there was nothing.
(Billie)

Billie conceptualised and utilised the NA concept of higher power in her own way. She said she wasn't 'God-orientated' but her description suggests a belief in some kind of omnipotent, benevolent spirit. Her reference to 'energy' could indicate a type of life force which may originate in New Age spirituality or Eastern religions. Moral action towards others was also at the heart of Billie's spirituality, as was self-belief.

Billie's spirituality also incorporated meditation. It helped her to calm the multitude of thoughts in her head and she saw it as a way to find answers within herself.

4.11 Amy

Problematic substance use

Amy is a 41 year-old female who had a problem with heroin along with a range of other drugs including speed, ecstasy, cocaine and alcohol. Amy experimented with solvents when she was around twelve years old. In her mid-teens, she started to drink alcohol and in her late-teens she started to use LSD, speed and cocaine as part of the club scene. At this stage, most of her drug use was during the weekends. When she was 24, Amy's life began to change for the worse when her Dad died. She moved to another city, and then broke up with her boyfriend. When she moved into a new flat she was introduced to heroin by one of her flatmates. Amy's heroin use became a bigger problem when she started dating a drug dealer. This is when her life started to 'spiral out of control' as heroin became a daily habit and she got into dealing drugs. Through injecting, she developed blood clots and abscesses, and because she wasn't eating properly she became malnourished. She built up debts with other dealers and got involved in criminal activities – shoplifting, fraud and theft. Amy tried to stop using several times. When she gave birth to her son, she stayed clean from heroin for a couple of years but she returned to using when isolation, boredom and depression got the better of her.

After about a year of further heroin use, Amy went to a rehab with her son. She spent nine months in the rehab during which she undertook a course that led to her getting a job. She also moved into a new flat. Her confidence and self-esteem grew through an education course she attended. This seemed to be a promising new beginning for Amy and her son. However, Amy's new job was not without challenges. While she had remained free from heroin since moving into the rehab, she discovered that alcohol and cocaine were part of her workplace culture, and she soon got involved. Two and a half years after Amy had entered rehab she took up heroin again. This affected her work and she was asked to leave. She soon got back into shoplifting to enable her habit. After a while she got onto a methadone script. This reduced her stealing, but she still was topping up with heroin most days.

Recovery

As Amy's life deteriorated further she realised that her drug use was having a negative impact on her son's life. This realisation, along with separating from her drug-using partner, spurred her to seek help from social work services. With the support of a social worker, she was admitted to a therapeutic community with her son. This gave her the time and space to participate in personal and group therapy. Her social worker and her son's social worker supported her through this and, when she left, they helped her to find a new flat and get linked with aftercare. Amy was supported through a Twelve Step treatment programme and through Narcotics Anonymous (NA). She described NA as 'the big thing' in her recovery. She received additional support from an employability service and a service for families with

substance use problems. Volunteering also became an important step in rebuilding her life. Amy had been in recovery for four years.

Beliefs

Amy's beliefs were rooted in her Roman Catholic heritage. She said, 'in your active addiction you sorta lose your faith'. But she still seemed to hold onto some semblance of faith as she still attended Mass during this phase.

I was walking about, living in an existence. I wasnae really living, I still believe - get myself into dangerous situations, and I maybe should of died, and I still believe there's somebody up there looking out for me . . . you know like, pushing out of my bed in the morning, when suicidal thoughts might have came in . . . I still believe somebody - I still believe n' that. I do believe in God, I do believe in God, but it's my God now. It's my God of my understanding (laughs). (Amy)

Looking back, she felt that God was looking after her, but her conception of God changed during her recovery. Amy's reference to the God 'of my understanding' is an indication of the influence of Twelve Step thought on her beliefs. Despite having had a Roman Catholic faith, she still struggled with the concept of a higher power as she encountered it in NA. Amy encounter a new concept of 'spirituality' in NA - she 'didn't even know what spirituality meant' when she first attended NA. Initially, she struggled to believe in God as she thought about the suffering and death in the world. Spirituality is still something she struggles with at times. Despite these obstacles, Amy was able to develop a spirituality that helped her in her recovery. She learned to use prayer and meditation to improve her 'conscious contact with God' (a term taken

from the Twelve Steps). She also attended Christian churches of various denominations to explore her spirituality.

4.12 Catherine

Problematic substance use

Catherine is a 60 year-old woman who previously had a problem primarily with opium, methadone and amphetamines, during the late 1960s and 1970s. Catherine started to inject opiate-based drugs when she was a teenager and ended up on a prescription of methadone. Catherine became immersed in the drug culture of the time, including selling drugs. She turned to shoplifting to get money to buy drugs and her life and health became adversely affected as her drug habit took hold. She became homeless, developed abscesses through injecting, came close to overdosing and developed agoraphobia. Catherine was arrested for shoplifting and eventually given a custodial sentence for possession with intent to supply.

Recovery

Catherine believed being sent to prison was the 'catalyst' which marked the beginning of her recovery. Even though she used drugs in prison for a period, she came to the point where she was ready to change. In prison, she participated in psychotherapy and she was supported through visits from her parents and a Roman Catholic priest. When Catherine left prison, her mother-in-law gave her moral and practical support, helping her to build a new life. Attending Mass in the Roman Catholic Church was an important way for Catherine to feel part of the local

community. Catherine's recovery became established through pursuing education and employment in the social care field. As her life progressed, she moved away from her Christian beliefs and explored Buddhist thought and practice through meditation. She also participated in psychotherapy. Catherine perceived herself as having recovered. She saw the first stage of her recovery as recovering from the drugs, and the second stage was about understanding why she used drugs. It had been 35 years since Catherine last used any of her problematic drugs.

Beliefs

Catherine came from a 'very strong' Roman Catholic background. As well as being brought to Mass as a child, she went to a convent school. When Catherine started to take opiates in her mid-teens she moved away from being involved in the church and became immersed in the 'deviant' (her word) drug culture. Catherine developed a lot of shame around her lifestyle which was undoubtedly influenced by her family's conservative Catholic outlook. This shame came to a pinnacle when she was admitted to prison for five years for selling drugs. It was when Catherine was in prison that the Christian beliefs of her mother and the support she received from a prison chaplain played a role in reviving her Catholic beliefs. Catherine believed that attending Mass was a 'very important' part of the development of her early recovery:

It was important because it gave me some stability. And also connected to a part of me that was the Catholic. I think it was just . . . it was safety and it was comfort. It was like, "I'm now really straight" (whispered). I remember going to chapel on a Sunday . . . wheeling my daughter, feeling like, "Oh I feel safe now in the world" (whispered). So I was very much a member of . . . from a big Catholic family, so a lot of approval around that, I got. So a lot of it

underneath was having . . . I suppose was trying to pay back, “I’m okay now, everybody. I’ll show you how okay I am. Here’s how I’m okay - Job, life.” (Catherine)

Attending Mass was a ‘ritual’ that gave her stability, and a sense of safety and comfort. It gave her a sense of feeling good, connected and accepted. Catherine acknowledged that this was ‘embedded’ and ‘ingrained’ in her from her childhood. In retrospect she felt like she was participating in the Catholic religion because she felt like she had to somehow pay back her family and the priest who helped her, and also to assuage her sense of guilt.

Catherine’s Roman Catholic beliefs and practices were an important part of her early recovery (for around ten years) but she became disillusioned with the Catholic Church. Catherine eventually stopped attending Mass chiefly because of the priest’s attitude towards single parents (of which she was one). At one time she felt that she had been ‘saved’ by Catholicism, but in retrospect she concluded that she had actually saved herself. Catherine’s beliefs also evolved as she was exposed to new experiences, people and ideas that she encountered in her education and work in social care. Around 10 years into her recovery Catherine got involved in meditation influenced by Yogic spirituality (Osho), and ten years later in Asanga Tibetan Buddhism. She learned about Buddhist religion but ultimately became disillusioned with its religious dogma and ‘dogma’ in general. She is still drawn to Buddhist psychology, which she understands to be secular and humanist. She has also continued to maintain a secular practice of meditation/mindfulness.

4.13 Rab

Problematic substance use

Rab is a 39 year-old man who had a problem with alcohol. His problem was exacerbated by the use of other substances, especially speed, ecstasy and cocaine. Rab exhibited anti-social and high risk behaviour when he used substances. He became aggressive, caused fights and got in trouble with the police. Rab's drug problem was exacerbated by mental health problems. He was latterly diagnosed as having bipolar disorder. Rab believed he used drugs to self-medicate for his mental ill health. The negative consequences of Rab's problematic substance use included deterioration of family relationships, loss of all his friends, financial loss (business, house and car), involvement in high risk situations (fights, driving under the influence of drugs, car crashes), blackouts, criminal arrests, charges and sectioning (admissions to a psychiatric ward).

Recovery

Rab's recovery (or reinvention as he preferred to describe it) from problematic substance use was also recovery from mental ill health. Being sectioned seemed to begin to put things in perspective for Rab. Rab was sectioned on the first occasion for his anti-social behaviour while under the influence of substances. At this time, he downplayed his problem to the hospital staff and told them that he did not have a big problem with substances. A year later he was sectioned under more serious circumstances. The police were involved and he was deemed to be a danger to himself and others. This admission to hospital was the turning point for Rab. It was

the last time that he used any alcohol or other drugs. After leaving hospital, life was not easy for Rab. He felt that he had lost everything, he had no sense of direction and he thought his friends didn't want anything to do with him. For six months, he lay on his couch at home and ate sugary food. To help him avoid using drugs, he took Antabuse, got rid of his bank cards and stayed away from people who might help him to use. He was in a 'really dark place' and at one point attempted to take his life. Having the support of his wife, and encouragement of his kids helped him to get through. After his six months on the couch, Rab got involved in a support group for people with mental health problems, but he didn't feel at home there. Through going to the group he found out about a recovery support group for people with drug and alcohol problems. In this group he found other people with whom he could identify with and share with openly. He soon was linked with a peer support worker who became a good friend and a source of encouragement. Through his peer worker, Rab got linked in to Alcoholics Anonymous (AA). AA proved to be an important source of social support for Rab. Volunteering and finding work has helped Rab to build a new life. Rab had been in recovery for 3 ½ years.

Beliefs

Rab was christened in the Church of Scotland and his father was actively involved in the Church, however Rab never liked learning about religion because he 'found it hard to grasp'. He felt that his father's Christian beliefs were forced on him and he responded by largely ignoring them. AA became the main support resource for Rab

in his recovery, but he struggled to come to terms with the concept of a higher power, as the following segment from our interview illustrates:

The down side to AA is the spiritual side. Now, I don't think I've got a spiritual bone in my body, I need things to be - I'm very sciencey and I need things to be explained to me with proof, visual things. I find it very difficult to grasp a higher power. I find it very difficult to accept that there's something greater than myself. Visually, people say to me, "Look at - your group's the AA, see them as your higher power." I say, "But they're only there." Your steps that you've got, you know, Step two is turn your will and your life over to the power of God as you understand him. I cannae hand over something because, to me, that's procrastination. I'll hand it over, it's just such a, aw - it makes me cringe to hand something over to something that you've not got any - that's not a physical thing.
(Rab)

Rab said that he had thought and read a lot about the idea of God and higher power but ultimately couldn't grasp the concepts for himself. He came to the conclusion that having a higher power was not essential for his recovery. Rab's difficulty in accepting a higher power seems to have come from what he calls his 'sciencey' perspective – his need to see things to believe in them. Rab's beliefs could be defined as secular and naturalist. However, when I asked Rab to expand on his beliefs he admitted that it was 'complicated'. Rab talked about 'the fact that maybe aliens were involved in things'. He spoke about 'another race that could have put us here,' and 'there must be something out there that's giving us these things but I find it hard to grasp what'. Rab was open to the idea that there was something else out there that could fit in with his naturalist worldview.

4.14 Paul

Problematic substance use

Paul is a 41 year-old man who previously had a problem with alcohol. Paul started drinking socially as a teenager. By his late teens, he had drinking binges all weekend and by the time he was 21 he was drinking heavily on a daily basis – often around 18 tins of super larger a day. Paul's drinking contributed to him losing contact with his children, a broken relationship with his partner, and fragile relationships with his parents. In addition, he became homeless, lived in poverty, experienced extreme weight loss and had severe seizures when he stopped drinking.

Recovery

Paul's first serious attempt at recovery seemed to be prompted by an awareness of his deteriorating health. He thought to himself, 'Look, you've got a choice, live or die'. Paul successfully detoxed at home with the support of a local addictions service. During this time, he had his own flat and his relationship with his family was restored. However, after eight months, Paul returned to his old drinking patterns. The second time Paul tried to stop, he stopped without any substitute medication. He was determined to make a change even though he knew this was dangerous. What made the difference this time was his decision to get involved in a local peer-support group for people with addiction problems. Attending the group became Paul's 'sole purpose of living'. The group helped Paul to build his self-confidence. Volunteering and getting a job helping others built his confidence further and gave his life structure and purpose. Paul had been in recovery for 2 years and 10 months.

Beliefs

The core of Paul's beliefs appeared to be a belief in himself – a belief that he could chose his own path. Paul had received support from the local NHS addiction service which he credited for helping him. However, he also acknowledged his own role in his recovery:

They saved my life, basically. I probably saved my life, but they helped save my life, if you know what I mean? (Paul)

Seven times during our interview Paul mentioned that he had a choice, to live or to die, and he chose to live. Paul was clear to emphasise that this was something that he chose to do himself. Self-belief and belief in people indicates existentialist and humanist thought. Paul said he was not religious however, paradoxically, he admitted praying to God, 'take me' when he was suffering while drinking heavily. He also said that he thanked God from time to time:

I do, now and again, I say, "Thank God I'm alive still". And, "Thank God" . . . it's maybe just something that I say, but I dae, I say it quite a lot, to be honest with you, so I maybe dae have beliefs (laughs), you know? Because, I'm here for a reason. I got saved for a reason. (Paul)

Paul seemed to be exploring what he believed even as we discussed his beliefs. While his primary beliefs in his recovery were his belief in himself and in people, he appeared to have underlying beliefs in a God and a sense that there was a greater purpose to life.

4.15 David

Problematic substance use

David is a 45 year-old male who had past problems related to his use of heroin and multiple other drugs which included cannabis, amphetamine, ecstasy, temgesic (buprenorphine), LSD, cocaine, crack, alcohol and methadone. David grew up in a housing scheme where heroin and other illegal drugs were readily available. Many of his peers used illegal drugs and his brother had a heroin habit prior to his own. During his early teens, David started to drink alcohol. By his mid-teens David was smoking heroin and experimenting with a range of other drugs. He was admitted to hospital for his alcohol use, he was stealing to buy drugs and getting in trouble with the police. Despite being a promising student, David left school at 15 years-old. There were few job opportunities for David and he 'hated' his life. In his late teens David got involved in selling drugs. This was lucrative at times but when the money dried up he resorted to violent crimes to get money for drugs. David soon got caught up in the criminal justice system and was arrested, charged and imprisoned on numerous occasions. His drug-centred lifestyle contributed to distant relationships with his family, periods of homelessness and deterioration of self-care.

David first tried to stop using heroin around the age of 20. His attempt to stop lasted about ten hours. He got involved in addiction services soon after this and was prescribed substitute medications – dihydrocodeine, diazepam and later, methadone. David took methadone on and off for around ten years until he became abstinent. From his mid 20s, David was involved in a range of treatment services

including a crisis centre and a respite centre. In his late 20s he was admitted to a long-term residential rehab. He was asked to leave the rehab for using drugs and was then admitted to a half-way house. Around this time, David also attended Narcotics Anonymous (NA) occasionally. David's engagement with these treatment services only had limited success as he continued to use drugs. David's motivation to change was still low. Looking back, he thought that he became involved in treatment chiefly to appease his family and girlfriend. Being on methadone seemed to help him to a degree, as using it led to him not feeling the need to use illegal drugs every day and as a result, his criminal behaviour reduced. He described his pattern of drug using behaviour at this time as 'peaks and troughs' rather than going 'from bad continually to worse'.

Recovery

David's long-term recovery began when David was at a very low point in his life. David planned to commit suicide, but his family intervened in a timely way and at the time David interpreted this as an intervention from God. He said, 'It was a Damascus Road experience¹⁰, and it was the most profound thing that's ever happened to me in my life.' After this experience, David never used illegal drugs or alcohol again. David's response was to go to NA and AA meetings. A mentor in AA, who was Christian, proved to be an important source of encouragement and support for David. David's

¹⁰ This is a reference to the New Testament story of Saul of Tarsus (subsequently St Paul) having a vision of Jesus on the road to Damascus (The Bible, Book of Acts 9:1-9).

Christian beliefs were central to how his recovery developed. Later in his recovery, David had a crisis of faith and he found new resources to support his recovery. Education and work in the addiction field and social work enabled David to build a new life. New spiritual practices have also helped David to maintain his recovery – namely mindfulness and meditation. Volunteering in a recovery community has also been important for David. He had been in recovery for 15 years.

Beliefs

David described his religious background ‘west of Scotland Protestant’, but he had little practical experience of Christianity. Looking back, he described his idea of God as ‘very naïve in terms of religion’. He elaborated on his early beliefs as such: ‘so, I just think God, he created the world and Jesus, that’s probably, it’s a very, very, limited idea.’ David’s ‘Damascus Road experience’ appears to have been influenced by his basic knowledge of Christianity. It is likely that he would have encountered Christian ideas about God through his previous involvement in Twelve Step groups and Christian-influenced treatment programmes. As David took steps to take his life he drew on these beliefs, praying sincerely for the first time in his life as he understood it. He interpreted his brother’s unlikely visit on this occasion as an intervention from God. He believed that God had saved him from taking his life. As a result, he gained a new sense of hope and he embraced a higher power through faith in Jesus and the Christian God.

David credits the development of his belief to the influence of a Christian man, Danny, who he met in AA. Danny became a mentor for David. He lent him a book of daily

readings called *God Calling*¹¹ (Russell, 2005). David also attended a house group that Danny held: 'it was to develop your kind of relationship with a higher power.' David started to read other religious texts of a Christian origin, though not the Bible. He became evangelistic in sharing his new found faith. David had also attended NA meetings over the years of his problematic substance use. After attending AA for a while he returned to NA it became a big part of his life along with his new faith as the following illustrates:

I was just consumed by [my faith], and probably more so with NA. The NA just became my life, and I really believed that a higher power . . . and obviously my higher power was like some sort of Christian God associated with Jesus and all that. (David)

David's Christian spirituality was evidently very important to him in the early part of his recovery. His spirituality began to change as his recovery progressed. He started to question his belief in the Christian God as he read books about science and the origins of life and as he was introduced to new ideas in college. He had what he called a 'crisis of faith'. David thinks he is probably an atheist now. Because David had essentially lost his higher power, his ability to engage in NA was compromised. David still felt the need to maintain his recovery through communal spiritual practices. He got involved in meditation and mindfulness through a Buddhist centre. This enabled

¹¹ A book of daily devotional readings. The writers of *God Calling* were associates of the Oxford Group, an early influence of AA. It was written through means of automatic writing and has been labelled by some commentators as heretical and occultic.

him to 'improve spiritually' without the need to be associated with any organised religion.

4.16 Alison

Problematic substance use

Alison is a 44 year-old woman who previously had a problem with methadone and dihydrocodeine (both prescribed and purchased illegally), temgesic, benzodiazepines, ecstasy and heroin. Linked to her drug use, Alison suffered from depression. She worked occasionally, but was on long-term sickness benefit for long periods because of her dependence on drugs and clinical depression. Alison attended a private detoxification centre and was on a prescription of naltrexone¹² for eight months, but during this time she used benzos and alcohol. After this period, she used heroin occasionally and returned to using methadone.

Recovery

Alison's turning point came at a low ebb in her life. She had been clinically depressed for some time, she was signed off from work and she felt that she was 'just existing'. She had also observed that 'normal people' had a better life without using drugs. Alison had been working with a community psychiatric nurse (CPN) for some years who had told her about Narcotics Anonymous (NA). While it seems that her CPN had been encouraging Alison to go to NA for some time, Alison had reached a point where

¹² Naltrexone is an opiate blocker.

she was ready to ask her CPN if she would take her to an NA meeting. Alison's CPN helped her to get admitted to a detoxification programme at the local psychiatric hospital where she was prescribed Suboxone¹³. This helped her to stabilise and become 'physically clean'. The social support she received in NA, along with encouragement she received from her CPN, helped her to remain drug-free. Volunteering with a recovery community group helped her to build a new social network and gave her daily life a sense of purpose. Alison had been in recovery for two years.

Beliefs

Alison did not have any strong existential beliefs. When I asked her about her beliefs she said, 'just like the NA thing . . . what was passed onto us there'. She was not specific about what NA beliefs were significant to her. I asked her what her view was on the NA concept of higher power:

Peter: So I'm aware, in NA, that at least some kind of models with NA, spirituality, or the idea of higher power . . .

Alison: A higher power, aye.

Peter: Is that something you, kind of, just didn't really embrace, or . . . ?

Alison: Well, I believed it. I couldnae . . . I didnae have a higher power mysel' as such – well, mebbe I did – mebbe I believed that

¹³ Suboxone combines naltrexone with buprenorphine, a partial agonist which simulates the effects of opiates.

there was something out there, but I believe in, I suppose, just in nature, and d'you know, just . . . aye, just things happen for a reason, and it's what you make it, blah, blah, d'you know? I don't know. I don't know what I'm tryin' to say. Aye, life is what you make it, I think.

Alison's response suggested that her belief framework was not strongly defined in her mind. She believed in 'nature', suggesting a naturalist tendency, but her comment that 'there was something out there' suggests an openness to the spiritual. Her articulation of 'life is what you make it' suggest an existentialist viewpoint. Alison also mentioned that she was brought up with 'old wives tales' which she summed up with the maxim, 'Dinnae dae that, because that will happen! Dinnae dae this, that'll happen!' She had let go of these superstitions and her existentialism was perhaps a pragmatic response to counter them.

4.17 Ewan

Problematic substance use

Ewan is a 47 year-old man who had long-term problems with multiple drugs including alcohol and heroin. Like many of his peers, Ewan experimented with solvents in his mid-teens but alcohol and cannabis became his drugs of choice during his teens. When Ewan drank he often got involved in fights. Later in his teens he was charged with numerous assaults, police assaults, and breaches of the peace when under the influence of alcohol. Ewan was also dealing cannabis. Ewan believed that his cannabis use affected his mental health, particularly making him feel paranoid. Through the influence of a peer, he soon got involved in taking opioids (dihydrocodeine, temgesic)

and temazepam jellies. He tried smoking heroin but because he was scared of getting addicted to it, he only dabbled.

At first, Ewan was a 'functional addict'. He was able to work and use drugs simultaneously. He also went to university for a time. While at university Ewan's drinking increased and he sold cannabis to other students. When he was forced to leave university, largely because of his drinking, Ewan's drug use escalated. He got involved with a group of drug dealers who soon took over his flat. Ewan returned to smoking heroin, started to take it intravenously and began selling heroin. He regularly took multiple types of drugs, often in combination (including crack, amphetamines and ecstasy). He was prescribed methadone, dihydrocodeine and diazepam, some of which he sold to buy other drugs. Ewan described the deterioration of his life as a 'downward spiral'. He went from being a functional addict to having nothing.

Ewan's drug use fluctuated throughout his drug using career. There were times when he would abstain from certain drugs but continue to use others. Ewan tried to get 'clean' at various points with little success. Being on methadone did not seem to help Ewan to stop taking other drugs. In fact, Ewan said that he manipulated his GP to get extra prescription drugs so that he could use them to buy street drugs. A significant step towards recovery seemed to be when both his Dad and his brother were seriously ill in hospital. This inspired him to come off methadone and heroin. He tried to make a fresh start with the support of a work initiative for people with addiction

problems. However, this was a false start to Ewan's recovery. He continued to use alcohol, cannabis and crack and he stayed off heroin for just 3 months.

Recovery

The beginning of Ewan's long-term recovery seemed to be rooted in his encounter with a group of Pentecostal Christians and his subsequent embrace of the Christian faith. While his drug use did not change immediately, his faith seemed to be at the heart of his motivation to change. Ewan's turning point took the form of an intervention¹⁴ from his family. They persuaded him to return home and attend a Twelve Step based rehabilitation programme. When Ewan returned he got into the habit of attending NA meetings and after a few weeks he was admitted to the rehab.

Before entering the project Ewan went 'cold turkey' on his heroin and crack. Up to the time when he was forced to leave the project Ewan was 'clean' for 70 days, however he was still drinking. Looking back, he believed he was in denial about his drinking problem. Ewan was ultimately forced to leave the project because he took an opiate substitute after four weeks in the project. Ewan thought that being ejected from the project helped him to realise that he was not just an addict, but also an alcoholic. After leaving the project, Ewan attended both NA and AA. He managed to get back into the abstinence project within a couple of months. Ewan engaged with the one-to-one therapy, group work and Twelve Step meetings. He completed the

¹⁴ Family interventions are a recognised approach for motivating individuals with substance use problems (e.g. Miller et al., 1999)

full programme on this occasion and this was the start of his abstinence from his problematic substances, including alcohol. Ewan received support from a resettlement worker when he left rehab. Volunteering in a local recovery project and attending church were an important source of social support for him. As his recovery progressed, working in social care gave Ewan's life new purpose and meaning. Ewan had been in recovery for 6 years.

Beliefs

Ewan's Christian belief were at the heart of his recovery. Ewan identified the beginning of his Christian faith with the visit of two Pentecostal Christian evangelists to his home. They wanted Ewan to pray with them. Ewan was resistant at first but eventually gave in. This proved to be a powerful experience for Ewan. This is how he described it:

I was thinking, this man knows what he's on about, and they were wanting me to pray with them, and I didnae want to pray . . . I was saying, "Look, I believe in the historicity of Christ. I believe he was real. I believe he walked this earth, but I didnae ken if I believe he was the son of [God]" and then, like, they asked me to pray and . . . well, a nanosecond before I prayed with them, I prayed in my own head and I went, "If you're a real God, I want to know. I really want to know," because . . . you know, it was, like, really quick thinking . . . I was thinking, but if . . . you know, I mean it, "If you're real, let me know." I prayed with them, and I felt something . . . it was just, like, a peace and glow, you know, it was tangible. (Ewan)

Even while Ewan continued to use drugs after this experience he started to go to church, read the Bible and pray regularly. Ewan recounted having a number of

spiritual experiences which he understood to be encounters with the Christian God. His beliefs around recovery were also influenced by Twelve Step philosophy.

4.18 Jasper

Problematic substance use

Jasper is a 56 year-old man who had a historic problem with alcohol. Jasper started to drink when he was 18. He got a job working in a factory that produced alcohol. He drank socially with his colleagues at first but his drinking started to get out of control. His drinking affected his marriage and relationship with his children and he had serious withdrawal symptoms when he didn't drink. Jasper's drinking deteriorated further when his wife died. He had a mental breakdown and attempted to take his life. As he drank more, he fell out with his children, amassed debts, he neglected his appearance and his health deteriorated.

Recovery

Jasper became tired of being drunk and ill. After years of increasingly heavy drinking Jasper tried to stop with a home detox through the support of his local community addictions team (CAT). After of a couple of failed home detoxifications his GP suggested that he try a residential detox ward (NHS). Jasper detoxed for two weeks and then was supported by his CAT worker to get involved in a community-based abstinence programme run by a voluntary sector organisation. He attended AA for around 3 months but this wasn't for him. He also got involved in a SMART recovery group, which suited him much better. Volunteering in a recovery community group

and working with people with substances problems helped Jasper to progress in recovery. Rebuilding his relationship with his children has been an important part of rebuilding his life. Jasper has used meditation, acupuncture and qigong¹⁵ as practical tools in his recovery. Jasper had been in recovery for 17 months.

Beliefs

The heart of Jasper's belief framework was a belief in himself. He struggled with the spirituality he encountered in AA, and in reference to the Twelve Step concept he said, 'my higher power is me'. He elaborates his view in the following quote.

I kind of struggle with spiritual. I've never been into any religion at any time in my life. I find it very difficult to put my reliance in anything else bar me . . . I believe in myself an awful lot . . . my belief is that believing in myself keeps me sober and keeps me, as I say, going out every morning not intentionally to hurt anybody, and do as best as I can, when I'm able to. (Jasper)

Jasper's self-belief indicated a secular existentialism, yet he did have some spiritual beliefs, experiences and practices in his recovery. He explored Buddhism, meditation, qigong and acupuncture during his recovery. Jasper recounted a story about having acupuncture and practicing qigong on a mountainside. He said this experience was 'quite spiritual'. He talked about feeling a sense of 'the universe being with you' and 'being one' – ideas that are usually associated with Buddhist or New Age thought.

¹⁵ Qigong is an ancient Chinese health care system that integrates physical postures, breathing techniques and focused intention.

4.19 Rachel

Problematic substance use

Rachel is a 52 year-old woman who had a past problem with alcohol. Rachel's alcohol problem was superseded by a compulsive overeating habit and further complicated by mental health problems (a nervous breakdown, depression, Post-Traumatic Stress Disorder), and relationship addiction. She saw herself as a white collar, highly performing alcoholic. She was able to hold down jobs but she was 'not present' to her children, had a bad temper, couldn't manage relationships and was suicidal.

Recovery

Rachel's recovery from alcohol began with her recovery from compulsive overeating. It was during this that she first realised that she also had a problem with alcohol. Rachel had been in private psychological therapy for her mental health for some time before she recovered. Rachel said that her recovery 'progressed in fits and starts'. Things started to change for Rachel when one of her colleagues, who was in alcohol recovery, suggested that she attended a Twelve Step recovery group for people with compulsive overeating (Overeaters Anonymous, OA). Listening to the experiences of other people in OA helped Rachel to realise that she was 'an addict' and that she had to 'surrender'. Rachel was abstinent from her problematic foods (chiefly sugar) for 6 months, but when faced with a difficult life situation she relapsed and her compulsive eating became worse than before. Rachel's second meeting at OA was another landmark in her recovery from compulsive overeating. On this occasion she 'felt at home there' and she was able to identify with the people that she met. Rachel started

to attend the meetings weekly and then several times a week. She wanted to learn more about the Twelve Steps and she started to attend AA meetings. It then became evident to Rachel that she also had a problem with alcohol which facilitated her overeating behaviour. Rachel recovered from her alcohol problem through engaging with the AA programme. She continued to receive support from her personal therapist (practicing transpersonal psychology). Rachel was also involved in Buddhist practice before and throughout her recovery. Buddhist mentors were also important source of support to Rachel in her recovery. Practising Buddhist meditation and engaging in Buddhist community was also helpful for her. Rachel's recovery has developed through working in the recovery community. Rachel had been in recovery for 12 years.

Beliefs

Rachel did not have a religious upbringing, but got interested in Buddhism around 8 years before her recovery began. From her Buddhism she learned that 'peace was possible' but she found that her spirituality was not enough to enable her recovery. She described the foundation of her Buddhist spirituality as, 'I don't think I am my thoughts'. Rachel's spirituality was non-theistic in that she did not believe in a God. During her recovery, her beliefs also incorporated Twelve Step ideas. She said that she picked up her definition of spirituality from a person at AA. She describes spirituality as,

. . . big, it's not institutionalised, it's that human dimension, the transcendent self, that fact that humans do amazing things every

day, that's just about being human, that's a function of human and we need that. (Rachel)

From the Twelve Steps she adopted the belief that she was an addict and that she needed to surrender. Practising honesty, carrying out a moral inventory (Step four) and sharing it with another human being (Step five) were core beliefs that she adopted from the Twelve Steps. It was also likely that Rachel's beliefs were influenced by her years in therapy. Transpersonal therapy tends to integrate spirituality with psychology.

4.20 Olly

Problematic substance use

Olly is 31 year-old man who previously had a problem with alcohol along with heroin, ecstasy, amphetamines, cannabis and crack. Olly started to drink and take drugs when he was 16. He used substances to help him to feel normal and to deal with his negative emotions. He also had an eating disorder at this time. From the start he used substances to excess. This led to him getting in trouble with the police, getting involved in fights, shoplifting, passing out and ending up in hospital, and becoming homeless. By the time he was 19, he was in and out of prison for violent assaults and missing bail. His mum encouraged him to attend AA at this time but he chose to go drinking on most occasions. During his mid-twenties, Olly was in and out of various rehabilitation centres with little progress. He started dabbling with heroin and crack at this time. He had a 6 month stay in a Christian-based rehabilitation programme where he read about Christianity and learned to pray. After leaving this, Olly

experienced auditory hallucinations which he interpreted as demonic forces. While he had similar experiences in the past, these were more intense. Olly was admitted to a psychiatric ward and returned to the rehab for a short time. When he left, his drinking became worse and he experienced more severe physical symptoms, including vomiting blood and having seizures.

Recovery

Olly applied for a place in an abstinence-based, Twelve Step-influenced recovery programme and after a six month wait was admitted. Sharing with a therapist in the programme was very beneficial to Olly. He followed their advice to get involved in AA. Olly attended '90 meetings in 90 days,' embraced a higher power and prayed every day. Olly's spirituality was at the heart of his recovery regime. When he left the rehab he moved into supported accommodation and after a year sober, he moved into a new flat. Helping out in AA became an important aspect of his recovery. Olly's recovery has developed through working part-time and studying for a degree. Olly had been in recovery for three years.

Beliefs

Olly's spiritual beliefs were a core part of his recovery. Other than being aware that his Nan was a Roman Catholic, he had an essentially secular upbringing and was 'more atheist than anything.' The first main influences on the development of Olly's spirituality was his time in the Christian-based rehab, where he learned about Christianity and learned to pray. He thought that they were 'getting closer and closer

to the truth.’ His subsequently ‘spiritual’ hallucinatory experience appeared to be verification for his sense of a spiritual dimension:

I’d had a few experiences . . . of like, well, being convinced that the devil, the devil, I was speaking to the devil, or at least dark forces (laughs), quite a few times. I’m not a hundred per cent convinced that I wasn’t, actually. (Olly).

The second main influence on Olly’s spirituality was the Twelve Step philosophies he encountered in the abstinence-based treatment programme and in AA, where he was encouraged to find a higher power and pray daily. He was also taught to live by spiritual principles – being brave, courageous, faithful, humble, honest and willing. Olly did not embrace an orthodox idea of the Christian God. His higher power was a benevolent spirit but was otherwise left undefined.

4.21 Conclusions

Experiences of recovery from problematic substance use vary between individuals and their contexts (White and Kurtz, 2006). My participants displayed a range of different types of experience of problematic substance use especially in terms of: types of drugs used; length and severity of problematic substance use; and other complicating factors (e.g. mental ill health, eating disorders). Other factors such as gender, age and social and geographical context also impacted experiences of recovery. These variations in problematic substance use logically impact the trajectory of recovery pathways. For most individuals, recovery involves incremental change. There are various stages models which are attempts to plot the trajectory

and patterns that people go through in recovery (e.g. Frykholm, 1985; Waldorf, 1983; DiClemente and Prochaska, 1998). The stages of recovery my participants went through included realising that their substance use was problematic, resolving to change, making efforts to change, having periods of being drug-free (or controlled use), relapsing and repeating this cycle.

My participants' stories illustrate a range of different types of support and treatment resources that affect processes of recovery. These included interventions from or engagement with: family and friends; generic health and social care services; mental health services; generic therapeutic services (e.g. private counselling); specialist addiction services (detoxification services, rehabilitation centres, group therapy, counselling etc.); peer-support groups (AA, NA, CA, SMART); general religious organisations (churches, temples); and specialist religious or spiritual treatment/support services (e.g. Christian rehabilitation centres). Processes that facilitated recovery included therapeutic sharing and listening (one-to-one and in groups); re-establishing an old positive identity or constructing a new recovery/recovered identity; helping others and voluntary work; and maturing-out through lifestyle fatigue and confrontations with mortality (their own and those close to them). For some participants, beliefs and related communities and practices played a significant role in the recovery process. The beliefs held by these participants illustrate the presence of the common cultural influences as well as alternative influences and idiosyncratic interpretations. In the following chapters I will examine in detail: how my participants constructed beliefs in recovery; how they practised

their beliefs through community and rituals; and how they integrated beliefs in recovery through constructing meaning and identity.

5 Constructing beliefs in recovery

My question, ‘how do individuals construct beliefs in recovery?’ is underpinned by the theory of social constructionism (Berger and Luckmann, 1966; Berger; 1973), assuming that individuals construct their beliefs through social interaction, drawing on culturally available resources. In my examination of religious and spiritual beliefs and experiences, I have adopted a framework of methodological agnosticism (Smart, 1977; discussed in 3.2.2). It is not my aim to validate or invalidate the substantive truth or reality of my participants’ views or experiences. The position of methodological agnosticism leaves space for openness and hopefully respect for the accounts shared by my participants. In this chapter I will firstly outline the belief traditions adopted by my participants. Secondly, I will discuss how my participants defined and understood the key concepts of religion, spirituality and secular beliefs. This discussion will highlight the blurring between boundaries of types of belief. Thirdly, to facilitate a deeper understanding of the construction of beliefs and to provide a conceptual framework for my subsequent discussion, I will explore the concepts of cultural and personal belief systems. I draw on the concept of *bricolage* (Lévi-Strauss, 1966) to explain how personal belief systems are formed. In the concluding section, I will comment on how personal belief systems relate to recovery pathways and highlight both the conventionality and individuality of personal belief systems.

5.1 Belief traditions

My participants drew on multiple belief traditions to form their beliefs: Twelve Step philosophy, Christianity, Buddhism/Buddhist philosophy and various secular philosophies. Table 2 provides an overview of the broad belief traditions evident among my participants.

Table 2 - Belief traditions among participants

Participant	Twelve Step Philosophy	Christianity	Buddhism / Buddhist philosophy	Secular beliefs
Jo	✓	✓	✓	-
Nina	-	✓	-	-
Sean	✓	✓	-	-
Bobby	-	✓	-	✓
Julia	✓	-	-	✓
Matt	-	-	-	✓
Fiona	✓	✓	-	-
Anna	✓	✓	-	-
Mark	✓	-	-	✓
Billie	✓	-	-	✓
Amy	✓	✓	-	-
Catherine	-	(✓)	✓	✓
Rab	✓	-	-	✓
Paul	-	-	-	✓
David	(✓)	(✓)	✓	✓
Alison	✓	-	-	✓
Ewan	(✓)	✓	-	-
Jasper	-	-	✓	✓
Rachel	✓	-	✓	✓
Olly	✓	-	-	-
Total	14	10	5	13
(✓) = Past involvement				

The table illustrates the prevalence of different types of belief traditions across the sample. It also highlights that individuals may draw on multiple belief traditions in their recovery. In addition to belief traditions, participants also drew on a range of alternative philosophies. I will briefly discuss each of the traditions and alternative philosophies in turn.

5.1.1 Twelve Step philosophy

Twelve Step thought has been integral to the development of the recovery movement in Scotland (see Ch. 2.3.2). Fourteen of my participants were influenced by Twelve Step thought. The main indicators that a person had adopted a Twelve Step philosophy was their use of ideas, language and practices taken from the Twelve Steps and Twelve Step literature (e.g. higher power, powerlessness, moral inventory, spiritual awakening; Alcoholics Anonymous, 2013). All of these individuals were also actively involved in one or more Twelve Step fellowships at some point during their recovery. Twelve Step philosophy is rooted in the history of Alcoholics Anonymous, its historical figures (Dr Silkworth, Bill W., Dr Bob) and texts (especially the *Big Book* of AA; Alcoholics Anonymous, 2013). The AA tradition has evolved over time as different groups in different locations have sought to follow and adapt the tradition to their particular needs. Not only are these variations within AA groups in the interpretation and practice of the traditions, but alternative Twelve Step traditions (NA, CA etc.) have brought fresh interpretations and introduced new texts and narratives. So while participants who followed a Twelve Step tradition had some

common beliefs and practices, individuals also displayed variations in how they interpreted and applied the traditions.

5.1.2 Christianity

While Scotland has changed through processes of secularisation, Christianity is still the largest religious belief represented in the population and in many ways is still part of the Scottish psyche and culture (see Ch. 2.2.4). Ten of my participants drew on Christian beliefs during their recovery (an additional three indicated that they were influenced by theistic ideas, i.e. praying to a non-specific God/higher power). The main indicators that I associated with Christian beliefs were the adoption of Jesus Christ as God or as a spiritual role model, drawing on the Bible as a spiritual text, seeking a relationship with God through prayer and exploring faith through Christian institutions and communities. There were variations in how Christian belief was interpreted and adopted. This was influenced in part by which Christian sub-tradition they were associated with (e.g. Church of Scotland, Roman Catholic, Scottish Episcopal, Free Church of Scotland, Pentecostal).

5.1.3 Buddhism/Buddhist philosophy

Buddhism has grown in popularity in Scottish mainstream culture and specifically among the recovery community. Five participants acknowledged that they were influenced by Buddhist ideas. Two of these suggested that they were exposed to these ideas through their involvement in the hippy culture of the 1960s. Others seemed to be exposed to Buddhism through their local Buddhist centre, through

friends or through exposure to Buddhist meditation in treatment centres or the recovery community. Only one of the participants could be thought of as an orthodox Buddhist. The others drew on ideas and practices from Buddhism, particularly meditation¹⁶.

5.1.4 Secular beliefs

Scotland also has a rich history of secular thought and a large proportion of Scottish people have a largely secular outlook (see Ch. 2.2.4). Ten participants indicated that they were influenced by secular thought. Most participants were hesitant to put a label on their secular beliefs but they could be defined as atheistic/agnostic, existentialist, humanist or naturalist. A secular worldview did not always exclude elements of spirituality.

5.1.5 Alternative philosophies

Participants also mentioned a variety of alternative philosophies when they discussed the beliefs that were important to them in recovery. These came from a variety of sources including popular film, classic literature, New Age literature, and popular/humanist psychology. Alternative philosophies included universalism, pantheism, karma, spiritual energy and belief in aliens. Some participants seemed to be influenced by Eastern philosophies through their encounters with alternative

¹⁶ Several other participants practiced meditation but they did not ascribe their practice to the Buddhist tradition.

therapies including reiki, acupuncture, Qigong and Tai Chi. Several participants were also influenced by the philosophies that they picked up through their education (e.g. feminism).

5.1.6 Conclusions

The prevalence of different types of belief traditions accessed by the participants provides insight into their social, cultural and historical context – Scottish recovery culture in the early 21st Century. The presence of Christian belief should not be surprising considering the historical association between Scotland and the Christian church. While Christianity has diminished in influence, it is still the most prevalent religious belief in Scotland (National Records for Scotland, 2013). The influence of Twelve Step philosophy among my participants also makes sense among people connected to Scottish recovery culture. The promotion of Twelve Step fellowships among the new Scottish recovery movement and in Scottish Government policy has ensured that Twelve Step philosophy is more influential than ever. The presence of secular belief should also be unsurprising considering the secularisation of Scotland (Bruce et al. 2004; National Records for Scotland, 2013).

The influence of Buddhism is perhaps the most surprising finding at first glance. Only 0.2% of the Scottish population identify themselves as Buddhist (Scottish Government, 2014b). However, practices of meditation, mindfulness and yoga have grown in popularity among the general population in recent years, generating interest in Eastern philosophies and religions, including Buddhism. This influence

could be credited to both the increased multicultural nature of Scottish society and forces of globalisation (e.g. access to alternative beliefs via the internet). It may also say something about the influence of Eastern philosophies in Scottish recovery culture. It is not uncommon for Scottish addiction treatment services to provide Eastern spiritual practices and alternative therapies such as meditation, yoga, acupuncture, reiki and Tai Chi. Trends towards secularisation and the negative image of Christianity in Scotland may also encourage individuals to look elsewhere for spiritual fulfilment.

The prevalence of Christian belief among the recovery community in Scotland may be more common than in the general population due to the historical associations between Twelve Step philosophy and Christian ideas and due to Christians' historical tradition of involvement with people with substance problems (through associations, churches and voluntary sector organisations) (Cook, 2006). Also, 15 participants indicated having some kind of spiritual belief, which may be a higher incidence of belief than in the general population. Perhaps the influence of the higher power concept among the recovery community may make it harder for people to hold on to purely secular beliefs.

5.2 Understandings of beliefs

In order to discuss the role of beliefs in my participants' experiences of recovery, it is important to establish how they conceptualised the core concepts that were part of our discussion – religion, spirituality, and secular beliefs. These were concepts that

were introduced by me when conducting the interviews and the way that I used them inevitably had an influence on how participants understood and used them. The direction of our conversations was also led by my use of the terms belief systems/framework in the research paperwork and interview questions. I used the following statement to explain belief system / framework to my participants:

It has been said that there are many pathways to long-term recovery. Each person's pathway to recovery is influenced by the person's belief framework, system or worldview. Belief frameworks are commonly categorised as secular, spiritual or religious.

Participants responded to my questions about their beliefs by talking about their secular, spiritual and religious beliefs as discussed below. The fluidity and blurring of the conceptual boundaries of beliefs will become apparent as the discussion progresses.

5.2.1 Religion

It is perhaps unsurprising that most participants used the term *religion* to refer to the main world religions. The Christian churches (the Roman Catholic Church and Protestant denominations) and Buddhist sects were the religious institutions most commonly referred to, though not all Christians or Buddhists made use of the terms 'religion' or 'religious'. Several of those who did use religion made a distinction between their religion and their spirituality. Amy, for example, explained the difference between religion and spirituality in her understanding.

Peter: You've used the word spiritual and I mean, you say you go to [Roman Catholic] church, would you say you're spiritual and religious, or would you just say you're spiritual?

Amy: I'm a bit of both because I've still got my religion. I used to get confused, you know like, like my higher power, and what my God is, d'you know what I mean? But it's both. I don't know. I used to get, "Well who am I praying for, what am I actually listening for?" (Laughs) D'you know what I mean? . . . I mean there is only, to me there is only one God, it's my God, it's my higher power, that looks after me, and things like that. Aye, it's only for me and nobody else. That I've built up a relationship with, if you know what I mean?

Amy's religion appeared to be associated with her Roman Catholicism. For Amy, there was a definite blurring between the categories of religion and spirituality. Her spirituality was influenced by her religious belief, but it was chiefly about her relationship with *her* God, *her* higher power – a concept she probably adopted through involvement in NA.

David, who was also involved in NA during his early recovery, described himself as a 'religious zealot'. He had an alternative view of religion in that his religion did not involve any direct contact with a religious institution. He met with other believers in a higher power group but he did not attend church. His religion incorporated his Christian beliefs, rituals, way of life and some exposure to Christian culture through books and mass media (e.g. Christian TV).

In my discussion with Catherine I was conscious that, as she talked about her spirituality in relation to Buddhism and Roman Catholicism, I had imposed the

category of spirituality upon her. I wondered whether religion was a more accurate term for her experience of Catholicism.

Peter: So, I mean, maybe I've, kind of, imposed the word 'spirituality' on to what that was, maybe religion would be a better term for . . . ?

Catherine: Religion, yeah. It was religion . . . Yeah, it was part of, you know, you went to the chapel every Sunday. You know, it was the start of your week. You felt quite good. It was embedded, ingrained in me, from a child, you know. It was safety. It was connection. It was acceptance.

I may have imposed the category of religion upon Catherine's description, yet she agreed that religion was a better definition for what she had experienced in the Catholic Church. Her mention of attending chapel every Sunday and feeling connected and accepted suggested that ritual and community were a core part of her understanding of religion. Later in our conversation she revealed more about her understanding of religion when I suggested that Buddhism was not necessarily religious.

Peter: Yeah, 'cause Buddhism is not clearly religious, is it? It can be seen as a secular philosophy.

Catherine: It's a religion, it's the same. Tibetan Buddhism to me is just Catholicism for the Tibetans. It's the same, very ritualistic, I . . . you know, a lot of it is very similar. So I'm very interested in the early teachings of the Buddha as well, because he's seen as a very, he's very - a humanist, you know, and what any religion is put in a time, of setting of time and what the time and the Brahmins, in around that. So very interested in how things get obscured through different cultures - time in the world. So if I have a regular meditation practice - but it's very in terms of mindfulness now, and

I've done a lot of . . . and I still . . . go to a lot of the secular stuff at [the Buddhist Centre].

Catherine believed that the ritualistic nature of Buddhism defined it as religious. Catherine struggled with the 'dogma' of Catholicism or any religious or political belief system. She had specific issue with the oppressive, patriarchal nature of religious dogma and practice in both the Catholic Church and Buddhist religion. As a consequence, Catherine moved away from what she perceived to be the religious elements of Catholicism and Buddhism, choosing to adopt a spirituality influenced by secular Buddhist psychology, incorporating mindfulness practice.

Not unlike Catherine, later in his recovery, David was put off by what he perceived to be the religious side of Buddhism. David wanted to improve spiritually but he was put off by the use of prayer at a Buddhist centre he attended. Rachel also wanted to make a distinction between spirituality and religion. Despite being a Buddhist practitioner she said she did not believe in God. It seems that when considering Buddhism, the boundaries between religion and spirituality are especially blurred.

5.2.2 Spirituality

Scholars of spirituality generally agree that spirituality is a 'fuzzy' concept that can mean many things (Zinnbauer et al., 1997). The way the participants defined spirituality was varied, yet there were commonalities. As discussed above, spirituality was often used synonymously with religious belief or practice. An interesting example is Jo. She was a practising Roman Catholic in that she attended Mass and

sang in the church choir. In private, she prayed and enjoyed listening and singing along to recordings of Mass. Yet her faith was unorthodox in that she believed in the goodness of *all* beliefs and in her conception of God, she suggested that she had universalist and pantheistic leanings. The 'religious thing' was problematic for her, particularly what she saw as idolising the church and clergy. She identified with what she saw as the spiritual side of Christianity.

I think I like the spirit - I identified more with the spirituality, sorta pulled that side in from that. Yea, from the "Do as you would be done by, be nice to people." That people Jesus fought were the hierarchy, sorta thing. (Jo)

Jo seemed to be implying that spirituality was about values. The two maxims that she stated suggest kindness and compassion. She also identified Jesus as a model for spirituality and that his struggles against the religious and political hierarchies is also a key part of spirituality (as a value, this could be thought of as being anti-oppressive).

Like Jo, other participants associated particular moral values with their spirituality. A few used the synonymous Twelve Step term, spiritual principles. Spiritual principles or values are also a core part of religious belief systems. Ewan, for example, clearly makes the connection between the spiritual principles of the Twelve Steps and Christian values:

Folk make the Twelve Steps, the thing that gets you clean, but it's not, it's really the principles. The principles of humility, honesty, you know, willingness, confession, love and action. You know, and it just says "... these principles." It doesn't say, "... practice these Twelve steps". You know, and it's like ... What are the principles?

Just the things listed, and more, and they're not, well, they're Christian principles. (Ewan)

The spiritual values that my participants mentioned included: kindness; goodness; compassion; love; being anti-oppressive; honesty; doing the right thing; being gentle to yourself; having faith in people; turning love into hate; being non-judgemental; not intentionally harming others; helping others; being moral; brave; courageous; faithful; humble; and willing. In most cases, it appeared that they had adopted these values from the belief traditions that they ascribed to – chiefly the Twelve Step tradition, Christianity and Buddhism. A few also talked about influential individuals being models for their spiritual values, including Jesus Christ, Buddha and Carl Rogers.

Billie's understanding of spirituality drew on diverse philosophies. The main influence in Billie's spirituality was her involvement in NA. Through this, she developed a belief in a higher power and used meditation to connect with her higher power. Billie identified herself as a 'spiritual person.' In the following quote she describes what she meant.

I would say I was a spiritual person, Peter. I'm more on the thinking about good and bad energy, positive and negative, that sort of thing, be the best you can be. What you give out is what you get back. I do believe I am not on my own, I believe that I am being looked after. I can't define what it is that's looking after me but I do believe that is a power that loves me, that wants the best for me, and I tap into that to help me through my day to day. That's my belief today, whereas before there was nothing. (Billie)

The first thing that Billie associates with her spirituality is a type of moral philosophy. What she articulates resembles that idea of karma – morally good actions will

produce good outcomes, while bad moral actions will produce negative outcomes. To this, she links the idea of fulfilling one's potential, an idea found in existentialism and popular psychology. The second thing that Billie links to her spirituality is her sense of connection with her higher power, who she identifies as good and interested in her. Later in our discussion, Billie associated certain principles or values with her idea of spirituality: honesty; doing the right thing; believing the answers are within yourself; being gentle to yourself; having faith in people; and having a 'deeper level of consciousness'.

5.2.3 Secular beliefs

Secular was not a word used by many of my participants, suggesting a general unfamiliarity with the term. One participant, Matt, asked me what it meant and I suggested that it incorporated humanistic or atheistic ideas. Matt thought that his belief system was secular, but he went on to use other terms to explain what he believed. He said his belief system was 'evolving' (his use of this word in context suggested that he was referring to a belief in evolutionary naturalist science), 'not religious in any way,' and it was about 'backing theories up with evidence.' Matt went on to try to explain his secular belief system.

I'm no expert on it, but the size of the universe, and all that . . . and the grand scale of things, were not here for a very long time, and geology, in terms of whatever, without going into that - we're such an insignificant, ken, know what I mean? (Matt)

Matt made reference to science and the physical sciences (archaeology and geology) indicating that he had an 'empirical' science-inspired belief system. The only other participants who overtly used 'secular' in our conversations were Rachel and Catherine. Rachel used it to describe the addiction professionals' workplace culture, contrasting it with the spirituality of her and her peers' recovery experiences. Catherine used secular to describe her non-religious spirituality which was influenced by Buddhist psychology and the therapeutic ideas of Carl Rogers (1951).

While others did not use the term secular, their belief systems fell within a secular framework. Matt, Rab, Alison, Mark, Jasper all had no religious or theistic belief, while Catherine and David moved from religious/spiritual to atheistic, non-religious/spiritual beliefs. Mark and Jasper also combined secular beliefs with spiritual practice. Rachel had no theistic belief but she did not specify whether she thought of her Buddhism as religious or spiritual.

A number of people talked about secular belief in terms of belief in people (humanism) or belief in themselves (existentialism). Mark, for example, chose not to embrace the concept of higher power, rather, he based his belief system around people:

In Narcotics Anonymous, they talk about like God and a higher power and all that . . . it's not that I don't have that, I just choose not to, I don't call it God. If I was to call it, the way it was broken down to me, is a "gift of desperation" (G.O.D.), know what I mean . . . because the God thing is still not really that comfortable with me. So for me, if you were to ask me, if I was to be pushed really, like do you have a belief in God or anything, [recovery] works

through people, it works through people. And that's the way I've been trying to describe it to you, it works through people, that's my belief system. (Mark)

Paul, like Mark, didn't have any definable religious or spiritual beliefs. His belief system seemed to be based around belief in himself:

Recovery, for me, is taking it day by day, no running before you can walk. Just take it day by day and start believing in yourself. I've never ever had beliefs in my life, but I think I believe that there is something there for everybody, there is life after drink. (Paul)

5.2.4 Conclusions

This discussion of concepts has illustrated that there is a blurring of boundaries between the concepts of religion, spirituality and secular beliefs as they were understood by the participants. In general, religious belief was associated with religious institutions and traditions (primarily Christian and Buddhist). However, the way religion was practised and understood was not always conventional (e.g. David). Spirituality was, in some cases, used synonymously with religious belief or practice. More often, it was used to refer to something more subjective and individualistic. Jo made a distinction between hierarchical religion and her anti-oppressive spirituality. Amy had religious involvement in the Roman Catholic Church, but her spirituality was more about *her* understanding of her higher power. This was a common idea that points to the influence of Twelve Step thought. Belief in a God or higher power was common in descriptions of religious or spiritual beliefs though spirituality could not always be equated with theism.

Beyond intellectual belief, both religion and spirituality were associated with the holding of and living out of certain moral values. Some of these were rooted in religious or spiritual traditions, including the Twelve Step tradition. Some values and ideas are less easy to subscribe to orthodox belief systems (e.g. Billie). This suggests that conceptualisations of belief are also influenced by alternative cultural philosophies.

Conceptualisation of secular belief required more interpretation on my part because participants rarely labelled them. Most of the secular beliefs I encountered could be labelled as atheistic, agnostic, existentialist, humanist or naturalist. Those who drew on Buddhism seemed to encompass all three types of belief (secular, religious and spiritual belief). Those who had secular beliefs in particular had loosely defined belief systems, though even some of those with religious or spiritual beliefs featured somewhat fluid conceptualisations. My participants' personal understandings of concepts also evolved over time. In my interview questions I associated community, personal habits/behaviours and emotional/spiritual experiences with belief systems. While it could be argued that by asking about these factors in relation to beliefs I emphasised their importance, many participants seemed to verify their relevance to their belief systems in the illustrations that they shared.

The beliefs of individuals in recovery appear to span and transition between the categories of religion, spirituality and secular belief. This raises two issues. Firstly, most of my participants cannot easily be categorised as having either secular,

spiritual or religious recovery pathways, as implied in Best et al. (2010). Secondly, it raises a methodological problem in terms of how beliefs can be studied. In the next section, I will conceptualise cultural and personal belief systems to make sense of how the participants constructed their beliefs in recovery.

5.3 Belief systems

In order to facilitate the examination of beliefs in recovery, taking into account the blurring of boundaries between the religious, spiritual and secular, I have reconceptualised two pre-existing terms. These are ‘cultural belief systems’ and ‘personal belief systems’. Both are terms that are often used casually in the literature around religion, spirituality and belief, although neither has been well developed as concepts. To conceptualise cultural belief system, I have borrowed and reformulated elements from the established theories of belief system (Parsons, 1952), ideology (Parsons, 1952; Plamentaz, 1971), cultural system (Geertz, 1973), worldview (Geertz, 1973; Smart, 1995) and metanarrative (Lyotard, 1984; Stephens and McCallum, 1998). I use the term *personal belief system* to make sense of how individuals construct their beliefs. I draw particularly on the idea of *bricolage* (Lévi- Strauss, 1966) to explain how personal belief systems are formed.

5.3.1 Cultural belief system

Before solidifying *cultural belief system* as a concept, I used the terms *belief framework* and *belief system* informally and interchangeably in the research interviews. White and Kurtz (2006) refer to recovery ‘frameworks’ in relation to

religious, spiritual and secular beliefs although they do not explore the concept fully (see Ch. 2.3.3). Belief system has been used in a range of academic disciplines including sociology, anthropology and religious studies. The term is often used informally without the provision of an exact definition. One of the more influential uses of the term belief system came from sociologist Talcott Parsons who employs the term within his social systems theory (Parsons, 1952). Parsons does not provide a clear definition of the term but indicates that belief systems can be scientific, political and religious. He equates belief systems with ideologies, by which he means, 'a system of beliefs, held in common by the members of a collectivity' (349). He also distinguishes collective ideologies from personal ideologies. Parsons' chief use of belief systems is as collective ideologies on the level of broad social systems.

Converse (1964) also suggests that belief system corresponds with ideology, which he describes as, 'a configuration of ideas and attitudes in which the elements are bound together by some form of constraint or functional interdependence' (207). Ideology is a contested term that is commonly associated with political and economic systems of ideas (Eagleton, 1994). Traditionally, ideology referred to the science or study of ideas. The meaning of ideology has evolved to mean, 'a set of closely related beliefs or ideas, or even attitudes, characteristic of a group or community' (Plamentaz, 1971: 23). The Marxist understanding of ideology sees these religious belief systems as systems of 'false consciousness' which work to maintain the political, economic and social status-quo (23-31). Plamentatz (1971) and Fitzgerald (2000) have argued that religion should be thought of as ideology.

Parsons' conceptualisation of belief system is linked to his use of cultural system (1949), in which he categorises human existence into three levels of organisation:

(1) individual personalities, which are shaped and governed by (2) a social system, which is, in its turn, shaped and controlled by (3) a separate "cultural system" . . . which is a complex network of values, symbols, and beliefs, interacts with both the individual and the society, but for the purpose of analysis can be separated from them (Pals, 2006: 266).

The concept of cultural system was developed further by anthropologist Clifford Geertz in his essay, 'Religion as a Cultural System' (1973). Geertz saw religion as a cultural system, meaning, a collection of symbols (objects, gestures, words, events, etc.) which existed in the social world and influenced people's moods, motivations and conceptions of reality.

Geertz also employed the concepts of world view to explain religion. World views, according to Geertz, are 'the picture [people] have of the way things in sheer actuality are, their most comprehensive ideas of order' (Geertz, 1973: 89). Ninian Smart, the religious studies scholar, argued that religions and ideologies should be thought of in terms of *existential worldviews* (Smart, 1995). Worldview has been developed in more depth as a concept by scholars than has belief system (see Naugle, 2013). As with ideology, there is a number of views on the meaning of worldview. Worldview is used in a distinct way in scientific discourse to distinguish different science-based perspectives on the physical universe, e.g. an Aristotelian or Newtonian worldview (De Witt, 2004). Plamenatz suggests that a worldview is a 'total ideology' (1971: 27). Other considerations are more concerned with how an individual may or may not

embrace a particular worldview (Sire, 2009; Hiebert, 2008) One of the more comprehensive definitions comes from Olthuis:

A worldview (or vision of life) is a framework or set of fundamental beliefs through which we view the world and our calling and future in it. This vision need not be fully articulated: it may be so internalized that it goes largely unquestioned; it may not be explicitly developed into a systematic conception of life; it may not be theoretically deepened into a philosophy; it may not even be codified into creedal form; it may be greatly refined through cultural-historical development. Nevertheless, this vision is a channel for the ultimate beliefs which give direction and meaning to life. It is the integrative and interpretative framework by which order and disorder are judged; it is the standard by which reality is managed and pursued; it is the set of hinges on which all of our everyday thinking and doing turns (Olthuis in Sire, 2009: 18).

Olthuis's definition has a theological bias suggested by his use of terms such as vision, our calling and creedal. Sire suggests that worldview analysis can overemphasize the 'intellectual and abstract nature of worldviews' (2009: 19). Olthuis's definition makes some progress towards the more personal and emotional elements of worldview namely, meaning and purpose. These are sometimes considered to be characteristics of spirituality (Cook, 2004). This definition also includes a number of insightful elements about the nature of people's worldviews: they may never have been fully articulated or developed in any logical way; they may be based on tacit assumptions; they may change as a person experiences life; they direct and motivate action; they provide meaning and purpose to everyday life.

Sire (2009) develops the theme of the impact of culture on worldviews. He argues that the way that we express our worldview 'is deeply imbedded in the flow of history

and the varying characteristics of language . . . [e]ach expression of any general worldview will bear the marks of the culture out of which it comes'. (2009: 19). Sire goes further than Olthius in de-intellectualising worldview by proposing that it is fundamentally about the 'orientation of the heart,' it is a 'spiritual orientation' (20). This definition reflects Sire's particular theological bias.

The concept of metanarrative is also important to my conceptualisation of cultural belief system. Metanarrative was developed by Lyotard (1984) in his discussion on the postmodern condition. Lyotard proposes that postmodern means an 'incredulity towards metanarratives,' which he argues is a result of the progress in the sciences (1984: xxiv). Lyotard does not explicitly define metanarrative and the examples that he refers to focus on narratives within academic philosophical discourse (e.g. the dialectics of Spirit, the emancipation of the rational or working subject, the Enlightenment narrative). Stephens and McCallum (1998) offer a clearer and more accessible explanation of metanarrative. They propose that a metanarrative is 'a global or totalizing cultural narrative schema which orders and explains knowledge and experience' (6). They highlight that what they are concerned with are 'conservative metanarratives' which they elaborate upon in the following:

[T]hat is, the implicit and usually invisible ideologies, systems and assumptions which operate globally in a society to order knowledge and experience. The major narrative domains which involve retold stories all, in the main, have the function of maintaining conformity to socially determined and approved patterns of behaviour, which they do by offering positive role models, proscribing undesirable behaviour, and affirming the culture's ideologies, systems and institutions. (3, 4).

Each of the theories I have discussed above has elements that were highlighted in the participants' accounts of belief, yet none of them provides a comprehensive framework for understanding how individuals in recovery construct and practice their beliefs. In addition, these theories carry a certain amount of unwanted epistemological baggage (e.g. ideology as false consciousness). Taking these theories further, I define cultural belief systems as *the established collective intellectual, social and practical frameworks for giving life meaning, purpose and structure*. A cultural belief system incorporates the following components:

- Core narratives
- Core texts
- Role models
- Theories
- Sub-narratives
- Established ways of speaking (language)
- Communities/social institutions
- Communal and personal practices/rituals
- Values
- Behaviours

Among my participants, the main cultural belief systems represented were Christianity, Twelve Step philosophy, Buddhism, and secular philosophies (e.g. humanism, naturalism). At the heart of each cultural belief system are core narratives (e.g. the story of the Bible and church history; the story of Buddha; the story of Dr Bob and Bill Wilson; the story of modern evolutionary science). These often emerge from core texts (e.g. the Bible; the *Buddhavadana*; the *AA Big Book*; Darwin's *Origin of the Species*), which in turn provide role models (Jesus; Buddha; Bill Wilson; Charles

Darwin). Sub-narratives may include stories about important historical figures or the personal stories of those who are part of related communities (e.g. the stories of a sponsor in AA; the testimony of a Christian minister). Table 3 provides examples of some of the components of cultural belief systems that were prevalent among the participants. Each of the cultural belief systems I have mentioned are generalised and do not portray the differences of belief and practices represented by sub-cultures within broader cultural belief systems (e.g. Christian denominations; Buddhist sects; the various Twelve Step fellowships).

Table 3 - Cultural belief system components – examples

Cultural belief system	Texts	Role models	Theories	Values	Community	Practices
Christianity	Bible, Catechisms	Jesus, St. Paul, The Pope	Sanctification	Forgiveness, kindness, justice	Christian churches, monasteries	Prayer, Mass, baptism
Buddhism	Buddhavacana, Mahayana Sutras, Pāli Canon	Gautama Buddha	Karma	Right view, right action, mindfulness	Buddhist temples, monasteries	Meditation, yoga
Twelve Step Philosophy	AA Big Book, Just for Today	Bill Wilson, Dr Bob.	Higher power	Powerlessness, humility, honesty	AA, NA, CA	Prayer, moral inventory
Naturalism	Origin of the Species, Selfish Gene	Charles Darwin, Richard Dawkins	Evolution	Rationality, empiricism	Scientific community	Scientific study

The way I have conceptualised cultural belief system portrays a bias towards narrative theory. I am subscribing to the assumption that stories, and especially the ‘big stories’ are at the heart of what motivates people and gives meaning to their lives (McAdams, 1993). ‘Cultural’ indicates that these belief systems are culturally accessible. The effects of globalisation mean that many more cultural belief systems

are readily available to people in Scotland. 'Belief' is also important in that it points to the importance of faith in these stories. Even subscribing to naturalism requires faith in the doctrines of scientific method and theory. Cultural belief systems can be thought of 'systems' both in the sense that all the components are interconnected and in that they provide a whole framework for living – intellectual, social and practical.

The concept of cultural belief system that I have presented provides the first stage of a theoretical framework for analysing the types of beliefs represented by my participants. While the concept of religion could be sufficient for aiding an understanding of Christianity and Buddhism, it does not fit well with Twelve Step philosophy and secular beliefs. Spirituality, in the diverse ways that it was presented by my participants, creates another methodological problem. Spirituality cannot strictly be thought of in terms of a cultural belief system. The term *personal belief system*, as presented in the following section, will make space for the diversity and fluidity of belief seen in spiritual beliefs.

5.3.2 Personal belief system

Cultural belief systems can be thought of as collectively held systems of belief. While this provides a broad framework for understanding the general types of beliefs and practices adopted by a group, in reality, the beliefs and practices of individuals within such groups vary from person to person. The diverse nature of Scottish society also means that many individuals do not neatly fit into one group. They may span several

groups, move between groups, or not be part of any group. *Personal belief system* is an attempt to make sense of both the conventionality and the individuality of belief.

Cultural belief systems and their components make up the main ingredients of a personal belief system. An individual may adopt one or more cultural belief system. In some cases, there may be a dominant or primary cultural belief system. Components from various cultural belief systems may also be combined. Those who adopt components mainly from one cultural belief system could be said as having an orthodox personal belief system. Those who combine a wide variety of components from various cultural belief systems can be thought of have a syncretic personal belief system. It could be argued that all personal belief systems are on a spectrum between orthodoxy and syncretism. A personal belief system may also include *alternative cultural components* (theories, language, texts, role models, sub-narratives, communities, practices, values). These may be gathered from other cultural sources which do not fit neatly into an established cultural belief system (e.g. a belief in aliens; practicing reiki). Personal belief systems also evolve¹⁷ over time and changes may range from minor to major. Such changes may be effected by encountering new ideas or responding to new life experiences. The way cultural belief systems and other ideas are interpreted or adopted is influenced by a person's unique history and life experience. Some changes may be dramatic, such as experiences of religious

¹⁷ I use evolve in a neutral sense, not meaning to imply that personal belief systems necessarily improve in quality over time.

conversion or loss of religious faith. I would also propose that personal belief systems are not always well defined cognitively. In summary, I propose that personal belief systems are *the unique combination of beliefs and practices that individuals adopt to make sense of the world and their lives and bring meaning to their existence.*

The concept of bricolage, initiated by Lévi-Strauss in *The Savage Mind* (1966), is helpful in understanding how people in recovery construct their personal belief systems. Bricolage, a French word, which can be roughly translated as ‘do-it-yourself’, was traditionally applied to the arts and has the connotation of gathering together diverse elements to create a unified form (Altglas, 2014). In his anthropological study of traditional societies, Lévi-Strauss used bricolage as an analogy to illustrate how new myths and religious systems are formed when people gather pre-existing cultural elements in new combinations. The form of new myths is limited by what is already available within the cultural vocabulary:

The elements which the “bricoleur” collects and uses are “pre-constrained” like the constitutive units of myth, the possible combinations of which are restricted by the fact that they are drawn from the language where they already possess a sense which sets a limit on their freedom of manoeuvre (Lévi-Strauss, 1966: 19).

Bricolage has taken on various meanings since its introduction by Lévi-Strauss (Altglas, 2014). Luckmann (1979), applied bricolage to the study of religion in modern society where the social influence of religious institutions has diminished.

The privatization of individual existence is linked to the privatization of religion in general. As for religious themes one is tempted to say

with some exaggeration: anything goes. In the global interpenetration of cultures, a vast – and by no means silent, although perhaps imaginary – museum of values, notions, enchantments, and practices has become available. It has become available “directly” but primarily through the filter of mass media rather than social relations. The choice is determined rather less by social conditions – although evidently they continue to play a kind of screening role – than by individual psychologies (136).

Luckmann suggests that the way individuals form their beliefs in modern society has been impacted by the privatization of individual existence and religion, and by the influence of globalisation, empowered through mass media. The individual has access to a more diverse range of beliefs from which they can choose without being restricted by the social pressures of previous times when religious institutions exercised a hegemonic power over society.

The term *bricolage* has been used to describe similar aspects of postmodern culture. The following use of *bricolage* by Roof (1993), applies to stories of belief in postmodern culture:

The post-modern world is a world of interweaving many stories. What we might call “multi-layered” meaning systems are commonplace, involving beliefs and practices drawn from a variety of sources, both religious and quasi-religious-including Eastern meditation, Native American religion, psychotherapy, ecology, feminism, holistic health, as well as more traditional Judeo-Christian elements. The result is “bricolage” or “pastiche,” a religious pluralism within the individual (307–308).

Altglas (2014) elaborates that in postmodern theory *bricolage* epitomises ‘a sense of fragmentation and deregulation of the social world – the death of traditions and great narratives, the implosion of social structures, the fragmentation of knowledge, the

collapse of boundaries between reality and representations, the mixing of popular and high art, the celebration of the local and the heterogeneous, the plurality of voices' (479). Bricolage in the postmodern world suggests an indiscriminate 'pick and mix' of beliefs.

Lévi-Strauss's (1966) use of the term bricolage suggested the gathering together of diverse cultural elements to form a new cultural belief system. This was limited by the constraints of what was culturally available. Bricolage as used in postmodern theory implies that: beliefs are gathered by individuals without constraints or limitations; traditional cultural belief systems and their narratives have been deconstructed; and truth is relativized. I suggest that the way cultural belief systems are formed among people in recovery lies between these extremes. Bricolage is helpful in illustrating how individuals construct their personal belief systems by drawing on a range of cultural belief systems and alternative cultural components. My data does not suggest that all individual are incredulous towards metanarratives, as proposed by Lyotard (1984). In fact, the majority of individuals adopt a primary cultural belief system that they use to bring meaning and structure to their lives. This is an individualistic process, but also limited by social constraints, as indicated by Luckmann (1979). Individuals often construct their beliefs in community and their connection to these communities requires a certain degree of orthodoxy of belief. Those who do not conform usually feel compelled to leave their community (e.g. David and Catherine). The individualistic nature of contemporary Scottish society

makes this possible yet individuals may feel the need to reconnect socially with another group that fits better with their evolved personal belief systems.

5.4 Conclusions

The aim of this chapter has been to elaborate upon how individuals in recovery construct beliefs. I firstly outlined how my participants drew on particular belief traditions as well as alternative philosophies, and how there was a blurring between religious, spiritual and secular beliefs. To make sense of the simultaneous adoption of common belief traditions, alternative philosophies and diverse interpretations and utilisations of belief, I conceptualised cultural belief system and personal belief system. I also used the concept of bricolage to facilitate understanding of the dynamics of the construction of personal belief systems.

Best et al. (2010) suggested that pathways of long-term recovery span ‘secular, spiritual and religious frameworks of personal transformation . . . [constituting] broad organising/sense-making frameworks for change’ (25, 27). It could be said that cultural belief systems correspond to the organising/sense-making *frameworks* for change, and personal belief systems correspond to *styles* of recovery (White and Kurtz, 2006). However, individual’s recovery pathways and frameworks cannot easily be categorised as secular, spiritual or religious. Individuals may have route of recovery initiation that could be categorised in these ways, but belief frameworks often evolve throughout recovery journeys.

Among my participants, personal belief systems were often conventional in that they were built around either one or two cultural belief systems. Individuals used the components of these cultural belief systems (narratives, language, communities, theories, practices, values etc.) to construct their personal belief systems. Some individuals also used alternative components to construct their personal belief systems. It may be that those involved in Twelve Step fellowships are more susceptible to individualistic, non-orthodox religious belief and syncretism because it encourages its members to find the 'god of your own understanding' - perhaps making Twelve Step groups 'melting pots' of belief. Engaging in belief orientated communities and practising rituals also affected the construction of personal belief systems (discussed in chapters 6 and 7). Life experiences also impacted the trajectory of a personal belief system. These were interpreted through processes of meaning-making and integrated into personal belief systems through constructing identity. These themes will be explored in chapters 8 and 9.

6 Practising beliefs in recovery (1): Community

In the previous chapter I addressed how individuals constructed belief in recovery. I explained how they understood religious, spiritual and secular beliefs, and how they constructed personal belief systems by adopting components from cultural belief systems and alternative philosophies. My focus was on the intellectual elements of belief, but I highlighted that personal belief systems also include practical components. I also suggested that personal belief systems develop and are reinforced through engagement with these practical components. In other words, the process of construction evolves through practical engagement. In the next two chapters, I will aim to answer my secondary research question, 'How do individuals practise beliefs in recovery?' In this chapter I consider the practising of beliefs in recovery through community. In chapter 7, I explore practising rituals.

It has been well established in the recovery literature that some kind of positive social engagement can be an invaluable source of support for people seeking to recover from problematic substance use (White, 1998, 2009; McIntosh and McKeganey, 2002; Best, 2014). This may be especially true for those with more severe problematic substance use (White and Kurtz, 2006). Recovery usually involves disengaging from problematic drug-using social networks and establishing relationships with a new social network or communities in which recovery is encouraged and/or supported (Koski-Jännes, 2002; Buckingham, Frings and Albery, 2013; Mawson et al., 2015;

Dingle et al., 2015). Among the participants, positive social support came from family, friends, peers in recovery, treatment professionals and people in religious/spiritual communities. Several participants benefited from the social support they received in therapeutic communities or similar residential treatment facilities (Rawling and Yates, 2001). Many participants especially expressed the benefits of peer support communities as a source of social and therapeutic support (i.e. Twelve Step, SMART and recovery community groups). I will argue that communities are also important in recovery because they can become the focal point for the construction and practice of personal belief systems. However, some individuals may be discouraged from engaging with certain communities due to an incongruence between the communities' cultural belief system and their personal belief system. In this chapter I will consider the relationship between communities, personal belief systems and recovery, addressing the communities that correspond to the cultural belief systems that I highlighted previously –Twelve Step; Christian; Buddhist; and secular¹⁸.

Table 4 provides an overview of the communities that were the main source of social support for my participants. Fourteen participants were involved in some type of Twelve Step fellowship. Some of these made use of the peer-support and community practices in a secular way while others took the spirituality of the programme on

¹⁸ I have excluded social support from family/friends, professionals and peers in residential treatment contexts from my analysis because, firstly these topics were not the focus of my interview questions around the role of beliefs in recovery. Secondly my participants did not usually highlight them as being of great import to the development or practice of their personal belief systems in recovery.

board (to different degrees). The fellowships represented included Narcotics Anonymous (7), Alcoholics Anonymous (7), Cocaine Anonymous (2), Al-Anon (1) and Overeaters Anonymous (1) (Six were involved with two types of fellowship). Eight participants regularly attended one or more Christian churches at some point during their recovery. Various denominations were represented including Roman Catholic (4), Church of Scotland (1), Free Church of Scotland (2), and various Pentecostal style churches (4)¹⁹. Three were involved in a Buddhist community. These consisted of urban and rural centres, including a monastery and temple (incorporating Triratna and Tibetan traditions). Some participants attended Buddhist centres simply to practice meditation in a form of secular spirituality, rather than to explore orthodox Buddhism. Six attended a secular recovery community group or peer-support group. Three were involved in a SMART or CBT recovery group. Involvement in different types of belief communities varied over time as personal belief systems evolved (words in *Italics* in Table 4 represent past involvement earlier in recovery). In the following pages, I will highlight the main factors that proved to be important to those engaging with different types of community. My discussion will include some of the general secular benefits of engagement as well as the benefit of religious/spiritual approaches.

¹⁹ In the following discussion, in order to maintain anonymity, I refer to Church of Scotland and Free Church of Scotland as Presbyterian. For the same reason, I use Pentecostal to refer to various Pentecostal/charismatic style sects.

Table 4 – Supportive communities in recovery

Participant	Primary community resources		
	Twelve Step	Christian and Buddhist	Secular
Jo	Alcoholics Anonymous	Church, choir (Roman Catholic)	
Nina		Church (Presbyterian)	<i>SMART recovery group</i>
Sean	Alcoholics Anonymous, Cocaine Anonymous	Church (Pentecostal), Christian recovery group and café	Recovery community group
Bobby		Church (Presbyterian)	
Julia	Alcoholics Anonymous		Recovery community group
Matt			Cognitive behavioural therapy (CBT) group
Fiona	Alcoholics Anonymous		Recovery community group
Anna	Narcotics Anonymous, Cocaine Anonymous	Church (Presbyterian, Roman Catholic, Pentecostal etc.)	
Mark	Narcotics Anonymous		
Billie	Narcotics Anonymous		
Amy	Narcotics Anonymous	Church (Roman Catholic, Pentecostal etc.)	Recovery community group
Catherine		<i>Church (Roman Catholic),</i> Buddhist centres	
Rab	Narcotics Anonymous		
Paul			Recovery peer-support group
David	<i>Alcoholics Anonymous, Narcotics Anonymous, Higher Power group</i>	Buddhist centre (mindfulness group)	
Alison	Narcotics Anonymous		
Ewan	<i>Narcotics Anonymous, Alcoholics Anonymous</i>	Church (Pentecostal)	<i>Recovery community group</i>
Jasper		<i>Buddhist centre</i>	SMART group
Rachel	Alcoholics Anonymous, Overeaters Anonymous	Buddhist centre	
Olly	Narcotics Anonymous		

6.1 Twelve Step communities

6.1.1 Friendship and shared experiences

For Rab, the benefit of attending AA was the supportive friendship and sense of acceptance he found there. Rab also highlighted the benefit of socialising with people who had stories similar to his own.

It was a room full of people who had similar stories to myself and the hand of friendship was set out and handed out to me and I'd never felt so accepted amongst anybody, because I kind of have to fight my way into groups my whole life, but the hand of friendship was extended to me and it was amazing. (Rab)

Alison, who also had a secular outlook, emphasised the benefit of being able to share experiences and identifying with the group members.

Just people sharing their experiences, d'you know, where they had came fae, when at times I thought, "Oh, I wasnae as bad as that" . . . They say in NA, kind of, you look at the similarities and no' the differences, what you have today. And identifying wi' people, d'you know what I mean? And then as I say, seeing where they were at that point, ken, been clean for whatever length of time. Aye. And I suppose it was just trust in what people were saying. (Alison)

This theme was repeated by Mark, again with a secular outlook. The heart of Mark's personal belief system in his recovery was a belief in people.

[Its] probably just the people thing for me. You know, the therapeutic value when you sit, and when you share honestly and open with another addict. Because nothing touches it . . . and that's my belief . . . If something happens, for me anyway, when I sit with another recovering addict and just share honestly with them, I get, it's a feeling thing. And I don't really know what that feeling is and

I don't really need to know. All I really need to know is it works, you know what I mean?

For Rachel, connecting with her AA community was part of what she saw as her healing process.

I needed to somehow let go and have that collective community healing, with other people who had the same illness as me, in order to get well. (Rachel)

6.1.2 Serving

Helping to run meetings was an important aspect of engaging with Twelve Step communities for several participants. Serving is built into the structure of Twelve Step Fellowships since the operation of meetings depends on members volunteering to take on various roles (secretary, treasurer, tea and coffee provider, greeters etc.). Amy, for example, served in her NA meeting and was active in supporting new women at her group.

I do service at that, setting up chairs, making teas, coffees, welcoming people . . . But like, you're talking about the community thing, that's like, maybe women coming out of the treatment. That's just like getting their phone numbers, getting, helping them in the community as well, you know like, going to meetings, meeting up for coffees, and things like that. That's how we support each other. (Amy)

For Amy, serving was about giving back to the community and trying to support others in the way that she was supported when she first got involved.

Julia helped out in her AA group as an opener or co-opener. She found that having the responsibility was positive for her, especially in helping her to avoid isolating herself:

I think having that responsibility, and I think the fact, you know, like I said I isolated myself. So maybe your social skills are very sort of . . . I mean, 'cause you're sitting at home, on your own, drinking, you're not interacting with anybody. You know, you're living in this fantasy world where you've just got maybe your music and your booze, and everything, you know, it's a total escape from reality. Whereas we're into AA and you're involved, it is reality. (Julia)

6.1.3 Spiritual community

Billie's spirituality was centred on her involvement in NA and she saw NA as an inherently spiritual community through which she felt an intimate connection to the people present.

You can walk in [to NA] and it's almost like a spiritual house, depending - you can feel that - I'm trying to think. The way I treat people all round is part of my spirituality. The way I am as a person and what I put out, and definitely in the NA rooms. I mean, you can feel that energy the minute you walk in the door. That sense of belonging, that knowing that this is where you should be, do you know what I mean? (Billie)

Billie felt a sense of belonging in NA which appears to have been facilitated by the energy she felt in the meeting place. This may say something about the emotional power that a social group can stir up for a person. Billie ascribed a spiritual quality to the group because of this tangible sense of energy and connection to the other group

members. She links the way she treats people to her participation in the community suggesting that participation is about reinforcing a certain kind of social behaviour.

6.1.4 Discovering a higher power

For some, engaging with a Twelve Step community was about discovering a higher power. Fiona's recovery was largely influenced by her involvement in AA and she embraced the spirituality of AA. It was through AA that she developed a sense of a higher power.

I think when you go into the [AA meeting] there, they'll say, ken, like, you realise that you're powerless over alcohol, but you also realise you're powerless over your life, and that's why you used alcohol. So I had to believe in something bigger than myself . . . but I do believe that there's a power out there that's bigger than me.
(Fiona)

David turned to the Christian God after he had a Road to Damascus experience, but rather than become involved in a Christian church, he explored spirituality through AA and NA. He also attended a higher power group which he said 'was to develop your kind of relationship with a higher power.' After attending AA for a while, NA became the main focus of his recovery and Christian spirituality.

I was just consumed by [my faith], and probably more so with NA. The NA just became my life, and I really believed that a higher power . . . and obviously my higher power was like some sort of Christian God associated with Jesus and all that. (David)

6.1.5 Struggling with spirituality

Those who came to Twelve Step groups with a secular personal belief system sometimes struggled with the spiritual side of the programme. This was particularly evident for Rab.

The down side to AA is the spiritual side. Now, I don't think I've got a spiritual bone in my body, I need things to be - I'm very sciencey and I need things to be explained to me with proof, visual things. I find it very difficult to grasp a higher power. I find it very difficult to accept that there's something greater than myself. Visually, people say to me, "Look at - your group's the AA, see them as your higher power." I say, "But they're only there." Your steps that you've got, you know, Step two is turn your will and your life over to the power of God as you understand him. I cannae hand over something because, to me, that's procrastination. I'll hand it over, it's just such a, awe - it makes me cringe to hand something over to something that you've not got any - that's not a physical thing.
(Rab)

Rab evidently struggled with the concept of higher power as it was presented to him in AA. It didn't fit with his naturalist outlook. Rab's response was to ignore the spiritual elements of the AA programme while taking advantage of the social and therapeutic aspects. Similarly, Mark struggled to accept the practice of prayer when he first encountered it in NA. Rather than reject this, he adapted prayer as a secular practice. Some others who tried Twelve Step groups, such as Jasper and Matt, were put off by the spiritual side, choosing to opt for secular support groups instead. For David, involvement in NA and a higher power group were foundational to his early recovery. Years later, when he lost his Christian faith and his belief in the disease model, he started to feel uncomfortable being part of NA.

I'm thinking, I can't go in there again and be a fake, I'm no being honest with myself, because I don't believe this and I don't believe that, and then if I manage to share, if there's a newcomer there I'm just going to confuse the bloody life out of them. (David)

David's change in beliefs ultimately led him to leave NA and find alternative sources of social and spiritual support.

6.2 Christian communities

6.2.1 Exploring Christian spirituality

Some participants attended Christian communities during their early recovery as a way of exploring Christian faith and spirituality. This was especially evident for the two women who tried out a variety of Christian denominations – Anna and Amy. Anna had no Christian background in her family and she had little prior knowledge about Christianity. Her motivation to go to church came from the spiritual experience that she had during her detox, in which she had a sense of a transcendent presence and the words, 'I am the way, the truth and the life' came to her (see Ch. 8.3). Since a child, she was aware that these words were written on a board outside a local Presbyterian church and so, six months after she became clean, she chose to go to this church. She interpreted what had happened as being called by God to attend church:

There's a big sign outside [the church building] saying "I am the way, the truth and the life". I've seen it from when I was a wee girl, when I heard that in my bed, when I felt that within my being, I thought "Oh, that's what it is, God wants me to go to church, that's God's calling me". This is my mad thinking. So it took me six months from

that night lying in my bed when that happened to go up to the church. When I went up to the church this minister's up preaching about this and that and . . . and I was terrified. [My daughter] was with me and I thought (gasps) "Oh, what if I turn?" And I spoke to him after and I says to [Rev. Smith], he introduced himself. I says, "I'm not coming back to your church." And I says to him, "and I don't know why," but I says to him, "I got clean six months ago" and I says "I thought I was to come here to learn about God," I says "because I don't know anything about God," I says "but I'm not coming back . . . cause I was scared listening to you." In a nice way, you know I said it to him. Because he was really nice, just a nice warmth of this man. (Anna)

Anna went to church to learn about God but she was scared by what she heard.

Despite being discouraged by her first experience of church she developed a good relationship with the minister and his wife. The minister came to visit her on a weekly basis to read from the Bible and chat with Anna. This relationship proved to be a valuable source of support for Anna. After about two years Anna returned to the church. She felt that she did this because of her 'people pleasing side' – to please the minister and his wife. Ultimately she didn't enjoy being at the church. She struggled with the way they spoke about God and with the exclusivity of what they preached. Anna explored different approaches to Christianity by attending different denominations:

I went to the [Pentecostal] church, loved it, but it was a bit, you know . . . Loved it, loved their singing and all that and their joy and their enthusiasm and their energy, like that, [my daughter] even liked the [Pentecostal] church. Went to [Roman Catholic] chapels, all their stuff's different because the Catholicism stuff is different like that as well. But it was a bit, mm... The [Presbyterian] with [Rev. Smith], really boring and dull and my God! It was like oh! Is this... And I spoke to [Rev. Smith] about it all and he would say to me "That's the devil in your head, [Anna]." And I'm like "Oh, for goodness sake!" (Anna)

Anna enjoyed the Pentecostal church and seemed to get something else out of Roman Catholic Chapel. She struggled to 'know what God is.' She still believed in Jesus Christ and the Bible but was aware that there were many different interpretations of Christianity around the world. Anna's interaction with churches allowed her to explore her Christian spirituality. When I spoke to her it was clear that she was still exploring what she believed. Anna benefited from the corporate worship of a group of people, especially in the Pentecostal church. While she didn't enjoy the Presbyterian church, it facilitated a new relationship with the minister and his wife, and this proved to be a valuable source of support to her in her early recovery.

Amy came from a Roman Catholic background and she had attended chapel prior to her recovery. After she became clean she started to attend church more often. The following is a snippet from our conversation:

Peter: So did you start going to church more when you got clean or?

Amy: Yea, you know what? I think it was like finding, I think it was like one of the ways of finding your faith as well. Y'know I go to the [Pentecostal] church or em, you know go about the cathedrals about [the city] and things like that. It's just to get inner peace with myself.

Peter: So you go to [the Pentecostal church] and the cathedral?

Amy: Yea, I've tried everything basically.

Peter: Yea, and do you kind of have a preference at the minute?

Amy: I don't know, I just like going to church, eh. I don't go to Mass or anything, I just like to sit, y'know by myself.

Amy believed that she went to church to find faith. Her past attendance of Roman Catholic Church suggested that she had some semblance of faith. Her experimentation with different churches suggests that finding faith meant exploring or deepening the faith that she already had. Amy talked about chatting with people in the Pentecostal church but her attendance of Catholic Church was about being present, listening and observing. This helped Amy achieve a sense of inner peace.

6.2.2 Connecting with Christian spirituality

Engaging with a church community as a means of connecting with God is implied in Anna's and Amy's accounts. Ewan stated this goal in a more explicit way. Ewan's engagement with AA was essential to his early recovery, but as a Christian, he also believed that he needed to connect with God through going to church.

I took the suggestion on "90 meetings in 90 days," but I also knew I needed God in my life. I also knew I had to come to church, 'cause it was alright just saying this is my higher power, my higher power and I wanted to have a relationship with God. (Ewan)

As well as connecting with God, Christian community could be a means of connecting with one's Christian identity (discussed further in Ch. 9). Jo struggled to connect with people in community and she was not sympathetic towards the hierarchy with the Catholic Church. However, attending Mass and choir connected her with her belief in goodness and connected her with her childhood self.

I love going to High Mass and I get a lot out of that . . . I think there's some, if, I think it's a belief in goodness, I think that's what I have . . . It was very important. It gave me a sense, em, I'm one of these people that would go to Mass three weeks in a row and then not go in three years. Em, but . . . when I got into AA, after I'd stopped smoking as well, that was my reward, to go and audition with the cathedral choir, so I did that and that gave me a bit of self-esteem, connecting, again connecting right back to my childhood, to really happy memories, of singing the Latin Mass and all that kind of stuff, and that was a connection. (Jo)

6.2.3 Giving back

An important part of Christian community was helping out in practical ways. For Sean, serving was an important expression of his Christian faith and helping out in the church café he attended helped him to connect more deeply with the community.

I do help out in the [church] café, it basically brings the community together, people from the community come in and it's fellowship as well. Just make teas and coffees and bits of cake and that, communication with other members of the community, like the folk that come in, they stay close to me as well. (Sean)

Contributing practically to the broader church community was also an important expression of Nina's Christian faith.

I go over [to church] on a Sunday and I make the bread for communion on a Sunday, once a month . . . I try to give something back, because of what, the help that's been given to me. Not by the people in the church, but by God. I try my best now to help other people, which I thought I did do, I thought I really did help other people, but I help them better now. (Nina)

Nina saw baking bread for communion as a way of giving back to God. She also contributed bread and food for social projects through the church community. Nina

saw helping people in church as a way of giving back to God, as an expression of gratitude. Helping out in church was also a way of establishing her new identity.

6.2.4 Discomfort and disillusionment

A number of participants who had a Christian faith during their phase of problematic substance use expressed a sense of discomfort, shame or incongruence of lifestyle in relation to Christian communities. Some of those in recovery also developed negative associations with Christian communities. Fiona, who was brought up in the Roman Catholic tradition, associated Catholicism with conformity, discomfort and fear. In her recovery she built her spirituality around AA instead. Jo was actively involved in Catholic community but she still felt uncomfortable and frustrated with the hierarchy in the church and what she perceived to be worshipping the church and the clergy. Catherine's discomfort with Roman Catholicism led her to leave the church and this was a step in her path towards atheism. She struggled with patriarchy in the church and specifically with how she felt she was treated as a single mum.

I suppose as a single parent, I think my whole question about my belief system started to be really questioned around that time, and I remember one day, sitting in mass one Sunday . . . and the priest going on about single parents and blah, blah, blah. "That's it" (emphasis). I'm not bringing my daughter to be subjected to this, you know. And it took a lot to say to my mother, and I remember at one point I thought of taking my daughter, she . . . went to Catholic primary school, you know, and my friend saying, why do you let them, sort of, overpower you? . . . I think I had a lot of stuff about trying to pay back, you know, guilt (laughs). (Catherine)

6.3 Buddhist communities

6.3.1 Stabilising and sustaining spirituality

Involvement in Buddhist communities did not appear to have any significant impact on recovery initiation or early recovery. It did however seem to be important in the stabilisation (post 1 year) and sustaining (post 5 years) of recovery. Rachel was involved in Buddhism before her recovery started. Going to the Buddhist centre gave her a sense of peace and hope:

One day I rolled up to Buddhist Centre. I don't know how I got there. And, learned to meditate . . . The thing that struck me the first time I went and sat in the shrine room . . . I knew I wasn't at peace, but knew that peace was possible, and that was all I needed . . . and I never knew that before. (Rachel)

Prior to her recovery, Rachel became more involved in Buddhism, becoming a spiritual practitioner and training for ordination to become a nun. When she started to attend Twelve Step groups she felt 'a great deal of shame' because she still wasn't coping despite being a spiritual practitioner. She also felt a sense of shame because of her eating disorder and alcoholism when she attended Buddhist retreats and compared herself to the other participants. Rachel admitted that it was only after about 2 years in recovery, 'my spiritual practice then paid off'. Buddhist mentors were an important part of Rachel's social network which also included AA, Overeaters Anonymous and professional therapists. Attending Buddhist centres and practising meditation was also helpful to Catherine during her sustained recovery when she was struggling with depression.

6.3.2 Secularising Buddhism

Rachel practiced orthodox Buddhism, which includes an atheistic worldview. When Catherine got involved in Buddhist community she had already become disillusioned with Roman Catholicism. As she became more involved in Buddhist communities she also started to struggle with what she perceived as religion in Buddhism.

I go to [the Buddhist centre] quite a lot and do things and different things, so it was very involved and then became very disillusioned again, because of patriarchy, abuse of power . . . I see myself very, in my spirituality, you know, I do mindfulness . . . in a very secular way. I think I'm very influenced by Buddhist psychology, but not the religiosity of it. Which can be tricky. (Catherine)

Catherine continued to engage with the Buddhist community but she frames her involvement in a secular way. David similarly became disillusioned with Christian and Buddhist religion and adopted mindfulness as a communal spiritual practice.

Well, that's the thing, I've always liked the meditation and I do believe mindfulness works, I do, well I did benefit from it, right. But, as I said, I'm no anti-religion now, but see everything with the religious stuff, I just felt everybody kept trying to put it on to you. So, when I found this [mindfulness and sharing group] thing, and they had the original meeting in [city], it was the first one ever around here anyway. Me and [my friend] went to it and that was my big attraction, because it was going to be improving spiritually, but it wasn't linked with any organised religion or anything. (David)

6.4 Secular communities

6.4.1 Connecting through activities

Julia found support from a local recovery community that organised social and interest groups and became a volunteer in the community. During her drinking, Julia's social life was based around going to pubs and she was generally 'incredibly lonely'. The recovery community allowed her to have a varied social life.

There was nothing like the [recovery community] . . . I mean they've got a dance class . . . they've got guitar groups; they've got something on a Saturday . . . But I've said for years they should have something because it is very isolating when you can't go to the pub. Especially if all your social life has been included in a pub. (Julia)

6.4.2 Benefiting through helping

Paul was involved in a recovery peer support group where he discovered that he was not alone in his addiction. As Paul's recovery developed he became a volunteer with the programme which included a walking group. His experience of helping and supporting others struggling with drink became an important source of affirmation and personal encouragement for him.

I mean, I was getting people coming up to me and saying, "Ken something, [Paul], you were brilliant on Friday. You just cheered me up no end, I didnae have a drink all weekend". See someone saying that to me, it's like, "Wow". It gets to you, you know? It's like, I've helped somebody not have a drink all weekend. [On a walk] we would give them a bottle of water and I would take the flasks home with me and I would fill the water up. They would buy the tea and the coffee and the sugar and that and I would just carry the rucksack and we would buy them sandwiches. And, if it was a crap day, we would take them to a café or go and play a game of

snooker, just basically to get them out. And, you could see their confidence levels just building. I mean, that was the world to me. (Paul)

Paul's experience in the peer group fitted well with his personal belief systems which was centred on his belief in himself and in people. Alison also volunteered at a recovery community. Helping in the community gave her life a sense of purpose and motivation that she didn't have previously. Sharing her experiences with the other people in the community also kept her grounded in her recovery. She saw her involvement in this community as crucial to her recovery.

I just share my experience with them, d'you know what I mean? Basically saying, if I can dae it, anybody can dae it; sort of, trying tae empower them and no' dae everything for them, and stuff like that. So, and that keeps me grounded, as well. . . So aye, recovery; the community is definitely . . . I totally believe in that. If that wasnae there, I probably wouldnae be here, to be honest. (Alison)

6.4.3 Self-empowerment

A SMART group was the main source of community support for Jasper. His personal belief systems involved aspects of secular spirituality with a strong emphasis on self-belief. For Jasper, the advantage of SMART recovery were the practical tools he could practise there (meditation, breathing and CBT exercises), and the emphasis on self-empowerment.

SMART's an empowerment, self-management recovery training. So it's self-managing, that's what I like about it, it's me, I can fix it, I don't need to go to somebody else to fix it. I can use all the things that's out there, but it's me using it the way I want to use it, I've got power back again. That's a really nice feeling, having your own

power back, control of your life. Because you've just got no control over anything, apart from your drinking, or your drugs. There's nothing, nothing is more important. (Jasper)

6.4.4 Clash of belief systems

Ewan faced some negative aspects of being involved in a secular recovery community as a result of his Christian beliefs. He felt uncomfortable with what he saw as dishonesty being promoted in the community. He also started to feel socially alienated when people in the community would tease him because of his faith.

I would go into volunteer at the [recovery community] . . . and it'd be, "Here comes [Holy Joe]²⁰." And then people that were supposedly my friends in long term recovery . . . They would get all agitated and . . . "Where's this coming from?" We were having a conversation . . . and the next thing it's like . . . there's a hidden agenda that they want to have a go at Christians? You know, and then I just felt like . . . there's times I've struggled with my faith. You know, any Christian does . . . when I see suffering, I try to make sense out of suffering. (Ewan)

Ewan felt persecuted from other people in recovery who he thought were his friends. This made it more difficult for him to engage with the community and to maintain his Christian faith.

²⁰ I have change the nick-name to protect Ewan's identity.

6.5 Conclusions

The themes and examples I have highlighted in this chapter suggest that connecting with communities was an essential aspect of recovery for my participants. Peer-support groups (Twelve Step or secular) were especially important in providing safe social spaces where individuals could find mutual support and participate in therapeutic sharing. Religious communities (Christian or Buddhist) could perform similar functions. One of the common themes that became evident across Twelve Step, Christian and secular communities was engaging through helping (serving/volunteering). Helping others in community deepened connection with the community and helped individuals to develop a sense of purpose and self-worth. This has been suggested previously by Zemore et al. (2004).

Engaging with communities in recovery was also relevant in that they could be the focal point for the development of personal belief systems. For several participants, communities facilitated the construction and reinforcement of personal belief systems through exploration and practice in community. Through engaging with groups of other 'believers', collective beliefs are both learned and reinforced. On one level this involves intellectual learning, but it also involves the social learning of normative behaviours, morals and values. Among the participants, the functions of community included: finding spiritual community and discovering a higher power in Twelve Step groups; exploring and connecting with Christian spirituality in church; finding sustaining spiritual practice in Buddhist community; and reinforcing ideas of

self-empowerment in a SMART group. An important part of this process was the construction of belief identities (see Ch. 9).

Different types of communities could also play different roles as recovery evolved over time. Twelve Step and secular recovery communities seemed to have particular relevance in the earlier stages of recovery. Christian churches were important for some in early explorations of spirituality and in sustaining recovery. Buddhist communities were important for a number of participants in later recovery in helping them to develop a secular spirituality.

Engaging with communities could also be problematic when personal belief systems came into play. For some of those with secular belief systems, the spirituality that they encountered in Twelve Step groups prevented them from participating fully or from participating at all. Christian community could also be a place of discomfort or shame, leading some to disengage. The religious elements found in Buddhist communities could be off-putting for those with secular beliefs. Secular communities could also be alienating for individuals with religious beliefs.

The themes suggested above should be interpreted bearing in mind that most participants were involved in multiple types of community, including various sub-cultures (i.e. Christian denominations, Buddhist sects and the various Twelve Step fellowships). Individuals borrowed philosophies, narratives, values and practices from a range of communities. It is therefore difficult to identify the influence of any

particular community on personal belief systems in recovery. People with similar personal belief systems also responded to communities in different ways.

7 Practising beliefs in recovery (2): Personal rituals

In chapter 6 I discussed how individuals practise their beliefs through community. All belief-orientated communities incorporate the communal practise of rituals with others in the community. Examples include, attending meetings, praying, meditation, talking and drinking coffee together. These activities are the practical means of social engagement. My participants practised belief-orientated rituals, in community and in private. Personal rituals are important for developing and sustaining personal belief systems. In this chapter I will focus on the rituals that my participants practised in private. These were primarily prayer, meditation and spiritual reading. These rituals were often used in combination as part of routine ritual practice. I will address each of the rituals separately, before discussing routine ritual practice.

Ritual, a term traditionally associated with religious or spiritual practice (Parsons, 1952), can be thought of as an action, or series of actions carried out in sequence, performed repeatedly at regular intervals. Ritual practices are defined by their symbolic meaning (Geertz, 1973). The series of acts associated with drug taking have also been thought of as rituals (White, 1996). White suggests that recovery requires the establishment of alternative rituals that support recovery. He defines recovery rituals as ‘activities that reinforce abstinence, promote physical, emotional, and spiritual health, and enhance personal identity and self-esteem’ (291). Recovery rituals could include, getting up and having a shower by a particular time each day,

eating regular meals, meeting a friend for coffee once a week, attending an AA meeting three times a week etc. The recovery rituals that I am concerned with are those linked to individual's personal belief systems, or in other words, those with symbolic meaning. Since spirituality is concerned with meaning making, I will refer to these as spiritual rituals.

Table 5 provides an overview of the personal spiritual practices highlighted by my participants²¹. The majority of my participants practised some kind of personal spiritual ritual as part of their recovery, the most common being prayer, meditation (or mindfulness) and spiritual reading. Other personal spiritual rituals that my participants mentioned were singing and listening to recordings of Mass (1), qigong (2), reiki (1) and acupuncture (1). I will now discuss how my participants used prayer, meditation and spiritual readings. While I will look at each ritual separately, it will become evident that there was often an overlapping of each practice. Two or more rituals are often used in a complementary fashion as part of a spiritual routine.

²¹ I only note personal practices that were specifically mentioned by my participants. Not all Christians talked about praying but it is likely that they did as part of their religious practice. Some participants evidently performed spiritual rituals in community, but most did not highlight these activities.

Table 5 - Personal spiritual practices

Name	Personal belief system	Personal spiritual practices			
		Prayer	Meditation	Reading	other
Jo	Spiritual/ Roman Catholic / catholic (AA)	✓	-	-	singing and listening to Mass
Nina	Christian (Church of Scotland)/spiritual	✓	-	-	-
Sean	Christian (Pentecostal) /spiritual (AA, CA)	✓	✓	✓	-
Bobby	Christian	-	-	✓	-
Julia	Secular (spiritual)/ AA	✓	-	-	-
Matt	Secular	-	-	-	-
Fiona	Spiritual (AA, Roman Catholic)	✓	-	✓	reiki
Anna	Spiritual /Christian (NA/CA)	✓	✓	✓	-
Mark	Secular (spiritual) (NA)	✓	✓	✓	-
Billie	Spiritual (NA)	-	✓	-	Tai Chi
Amy	Christian (Roman Catholic)/ spiritual (NA)	✓	✓	-	-
Catherine	Christian (Roman Catholic) →spiritual (Buddhist)/secular	-	✓	-	mindfulness
Rab	secular (NA)	-	-	-	-
Paul	Secular (spiritual)	✓	-	-	-
David	Christian → spiritual /secular (NA)	✓	✓	✓	mindfulness
Alison	Secular (NA)	-	-	-	tried meditation
Ewan	Christian (Pentecostal) / spiritual (AA, NA)	✓	-	✓	
Jasper	Secular/spiritual	-	✓	✓	acupuncture, qigong
Rachel	Buddhist/spiritual /secular (AA, OA)	-	✓	-	-
Olly	Christian/spiritual (AA)	✓	-	✓	-
Legend: → = Move away from one belief to another; AA = Alcoholics Anonymous; NA = Narcotics Anonymous; CA = Cocaine Anonymous; OA = Overeaters Anonymous					

7.1 Prayer

Twelve participants talked about praying during their recovery and, though they did not talk about it explicitly, it is likely that two others prayed as part of their Christian practice. Prayer, as practised by my participants, was a means of communicating with God or their higher power. It generally involved non-verbal or verbal expression of thoughts, desires and requests to God, and listening to God through emerging thoughts, feelings and events. Of the twelve who stated that they prayed during their recovery, eight had some kind of a Christian belief and had also been associated with a Twelve Step group (AA, NA or CA). One other had a Christian faith and no Twelve Step association, two others had only a Twelve Step association, while one had neither an explicit religious faith nor a Twelve Step association. Of the twelve who prayed, three had an essentially secular experience of recovery: one with no belief in a God or higher power and two with unexplored concepts of a God or higher power. Another person did not pray to a God but did talk about reciting the Serenity Prayer²².

My participants talked about prayer performing a range of functions. In most cases, practices of prayer emerged from either the Christian tradition or the Twelve Step tradition (which one might argue has its origins in Christianity). In the Christian tradition, prayer is usually thought of as a means of communication with God. This

²² 'God grant me the serenity to accept things I cannot change, courage to change things I can, and wisdom to know the difference' – a prayer accredited to theologian Reinhold Niebuhr (1892–1971), which has become part of Twelve Step culture (Alcoholics Anonymous, 2009).

perspective is still common in the Twelve Step tradition, however some of the accounts shared by the participants suggest that prayer can also be atheistic. In the following discussion I will firstly look at how participants used prayer prior to their recovery and then look at the three main purposes that prayer seemed to have for my participants during their recovery – connecting with God, providing strength and giving thanks.

7.1.1 Pre-recovery prayers

Some participants talked how they prayed before their recovery. Some of these participants saw prayer playing a role in their journey toward recovery. Ewan shared several incidents that suggested that finding God in his Christian faith eventually led him to his recovery. In one example, he talked about praying when he was discussing Jesus with a couple of Christian evangelists in his home.

They asked me to pray and . . . well, a nanosecond before I prayed with them, I prayed in my own head and I went, “If you’re a real God, I want to know. I really want to know,” because . . . you know, it was, like, really quick thinking . . . you know, I was thinking, but if . . . you know, I mean it, “If you’re real, let me know.” I prayed with them, and I felt something . . . it was just, like, a peace and glow, you know, it was tangible. (Ewan)

After Ewan had become a Christian, and started to attend church, prayer became important to him, not just as a means to connect with God, but as source of hope when he was struggling:

I went to church a few times gouching²³, just . . . ken, my head nodding away. I used to read my Bible and I would . . . I'd be crying, you know, at night after all the shit of the day, ken . . . and I'd be praying, ken, "Please help me, God. Please, please get me out of this. I want out of this. I want to change." You know, and I'd think that there was a way out. (Ewan)

Ewan believed that this prayer was answered when his family got together to help him get into treatment. This proved to be an important step in his recovery journey. It appears that for Ewan, having a faith and feeling like he could connect with God through prayer gave him a sense of hope and fuel for motivation. He believed that there was a power greater than himself who cared for him and could help him to escape from the chaotic lifestyle that he found himself in.

Prayer also proved to be an important ingredient in David's recovery story. David did not have any firm religious or spiritual belief before he recovered, yet he had an underlying belief that there was a God from whom he needed to seek forgiveness.

I used to think - see when me and [my friend] would do a robbery or something . . . I used to be like, "God forgive me for doing that," because obviously you're putting weapons to people and all that and it's fucking you don't care at the time. And I used to think this was me being a decent guy and all that, saying "God forgive me, look after they poor people, hopefully they're okay". (David)

David had a sense that his behaviour was wrong and perhaps an offense to God. He may have been seeking to appease a sense of guilt through praying for forgiveness.

²³ A sensation of nodding off to sleep, especially when under the influence of opiates.

David prayed more sincerely when he came to a point where he planned to take his life.

It was probably the first time I had ever prayed sincerely in my life . . . so I was praying, and I was like that, "Forgive me for this," I can't do it. (David)

Not unlike Ewan's circumstance, David saw the apparently coincidental intervention of his family as an answer to his prayers. David's long-term recovery and sobriety began from this point. He believed that God had saved him as a result of his prayers. David embraced a Christian spirituality which proved to be the main motivating force in his early recovery, though he later moved away his faith.

Paul used prayer in a different way. He didn't have a strong faith but he had a sense that God had control over his life, and death.

I used to wake up in the morning and go, "Oh no." I wasnae wanting to waken up, that's how bad it got. It was just like, I want to fall asleep and I don't want to wake up, "Just take me," know what I mean? I kept praying, "Please take me when I'm sleeping". (Paul)

Paul didn't ask God to forgive him or help him to change. His prayers seemed to be a desperate cry for a God that he had little conception of, to take his life. Paul's conception of God did not change dramatically when he recovered. Thanking God for being alive was the only indication of faith.

Other participants, including Amy and Jo, prayed during their active drug use as part of their Roman Catholic faith. They did not say much about the nature of their prayers

at this stage of their life. However, Amy expressed a sense of discomfort in attending Mass which would suggest that prayer may also have been uncomfortable. It is likely that some participants may have experienced a sense of guilt or shame as a result of their drug-centred lifestyle and that this may have been an obstacle to praying to a God of whom they may have felt they were unworthy.

7.1.2 Connecting with God

Ten of the participants talked substantively about prayer as a means of communicating or connecting with God or their higher power during their recovery. The following interview quotes illustrate how three of them used prayer to connect with God.

I can pray to God whenever I want to pray to God. God, as far as I believe, and my belief is that God's there when we need him. God's there every day beside you, you're guided through life. You're given choices, you choose your choices in life. Whether it's right or wrong, that's your doing. But, whatever they are, God is still there, whatever choice you make, he's still there . . . You can pray anywhere to God. You can talk to God every day. (Nina)

I believe there is a God . . . I know there is . . . my prayers have changed now Peter. And all I ask now in prayer is, "Help me to get to know you God. Please, Father, help me to get to know you better," cause I don't know where to go, what avenue to go down, what church to go to. And I don't want to disrespect anybody and that's what I pray for: "Please help me to get to know you. Help me to get closer to you and to know that I'm always in your company." That's all I pray for now. I will pray for people and stuff as well but I think it's all taken care of anyway. (Anna)

Yea, see my God's caring, d'you know what I mean? My God's caring, he doesnae judge me, you know it's always there for me no

matter what. But then that's when, I had to practise all this y'know, getting a conscious contact with my God. I had to do that through like praying and meditation. Y'know I've got to pray every morning, [to] just get me through the day - or pray or [give] thanks for the small things in life . . . I used to think it'd be all about material things but it's no. It's just like, getting up in the morning and having a flat over my head, having my son in my life, being able to be a parent again and to have that unconditional love for my son as well, because he was a hindrance. I couldn't do what I wanted, but now I appreciate things like that now whereas before I didnae . . . I didnae give a shit basically. But now I do appreciate the small things. (Amy)

Nina, Anna and Amy all used prayer as a means of connecting with their God. Nina talked to her God whom she sensed was near her, guiding her through life (this idea was repeated by Olly who talked about asking God for guidance when he had to make a difficult life decision). Anna asked God to help her to get to know him better, as well as praying for people. Amy saw her God as caring and non-judgemental and she saw prayer as a way of improving her 'conscious contact with God,' a term taken from Step Eleven (Alcoholics Anonymous, 2013). All of them had a sense that God was benevolent and present and that they wanted to deepen their relationship with their God.

7.1.3 Providing Strength

Another function of prayer seemed to be to provide mental strength to maintain recovery in the face of daily challenges. The following examples relate to individuals who had a theistic (not strictly Christian) idea of God.

I have that strength, that inner strength regardless, whether I pray in a church or a pray outside, do you know what I mean. (Fiona)

Y'know I've got to pray every morning, y'know like just pray, just get me through the day. (Amy)

I'd been instructed [in the Twelve Step-based treatment centre] that I need to get up in the morning and pray. Which I knew from [the Christian rehab], and I knew that it made me feel good. I didn't know why . . . I felt like I wasn't as scared anymore, and this stuff that I was doing, this getting up in the morning, first thing before I had to leave the house, and praying, was protecting me from potential disaster. And so I kept doing it. (Olly)

As well as being able to pray in church, Fiona felt she could pray anywhere and receive an inner strength. For Amy, prayer was a daily practice that helped her to get through the challenges of the day. Olly also built prayer into his daily routine. It made him feel good and he believed it protected him from returning to his drug use and the risky behaviour that surround that. It could be said that for Olly, prayer also provided strength through producing positive emotions. This seemed to be evident for Olly and Ewan (see Ch. 7.1.1), and was also clear from Jo's account of singing Mass, which could be considered a form of prayer. She said that it lifted her emotionally.

7.1.4 Giving Thanks

Giving thanks for one's life and particular for one's sobriety was also a recurrent theme.

Pray, or thanks for, you know, just for, for the small things in life, d'you know what I mean it's like, em, I used to think it'd be all about material things but it's no, it's just like, I don't know, just getting up in the morning n', having a flat over my head, having my son in my life, being able to be a parent again n', to have that unconditional love for my son as well, because he was a hindrance, I couldn't do what I wanted, but now I appreciate things like that now whereas

before I didnae, d'you know what I mean like, I didnae give a shit basically. But now I do appreciate the small things. (Amy)

I've thanked God every night for keeping me sober. I mean, I've done it every night for 15 years. I don't think I've ever missed a night. So I've done that every single night. I mean, regardless of the day I've had, it's never been as bad as when I was drinking, I've never had anything in the 15 years I've been sober that was ever as bad as the drinking, 'cause that was just horrendous. (Julia)

I do . . . now and again, I say, "Thank God I'm alive still". And, "Thank God" . . . It's maybe just something that I say, but I dae, I say it quite a lot, to be honest with you, so I maybe dae have beliefs (laughs), you know? Because, I'm here for a reason. I got saved for a reason. (Paul)

Amy was more appreciative of the small things in her life during her recovery and expressing this in prayer helped to reinforce her thankfulness. Julia had an essentially secular recovery and did not articulate any firm religious or spiritual beliefs. Despite this, she thanked God every night for her sobriety. This was perhaps a grounding routine that helped her to be reflective about where she had been and where she was now. Similarly, Paul had a secular recovery and no strong religious or spiritual beliefs. Even as he spoke he seemed to be coming to a realisation that he had a kind of underlying belief in God. Perhaps like Julia, Paul's practice of giving thanks was a reflective, grounding routine that was integral to the maintenance of his recovery. The practice of giving thanks may also have been picked up from Twelve Step Fellowships. The principle and practise of gratitude is central to Twelve Step philosophy (Alcoholics Anonymous, 1979).

7.2 Meditation / mindfulness

A total of nine participants talked about using meditation regularly. Most religious traditions practice a variation of meditation. It normally involves quiet reflection and excluding negative thoughts with the aim of gaining mental peace and physical relaxation. Eastern traditions, such as Hinduism and Buddhism, incorporate the use of mantras and controlled breathing (Eifring, 2014). Christian mediation is akin to prayer and the individual is meant to focus their thoughts on God (Eifring, 2013). Mediation is also encouraged in the Step Eleven of the Twelve Steps (see appendix, Ch. 12.7). Mindfulness has emerged out of the tradition of Buddhist meditation and it has grown in popularity in healthcare practice²⁴. It removes any of the religious vestiges of meditation, directing the individual to consider their intention, attention, and attitude (Shapiro et al, 2006). Of the nine who had used meditation, seven were associated with a Twelve Step group. Four had an association with a Buddhist centre. Four used meditation in unison with prayer, of which all had a Twelve Step association and three had a Christian faith. Six of those who meditated had an essentially atheistic outlook. Of these six, two adopted mindfulness as a purely secular alternative to meditation. The main functions that meditation had for my participants were finding peace of mind and connecting within and outside oneself.

²⁴ See <http://www.mindfulnessscotland.org.uk/>

After discussing these two themes, I will briefly consider mindfulness as used by my participants.

7.2.1 Peace of mind

Several participants described how, during their recovery, and especially early recovery, they were being bombarded with a plethora of thoughts. Meditation provided a means to help them to calm their thoughts and achieve some peace of mind. The following statements by Amy, Mark and Billie illustrate this point.

[Meditation is] just having to sit with myself, d'you know, just like sitting with myself, cause you know I'm still an addict so my head can still be like a radio, d'you know what I mean? It can be on a high [laughs] pitch radio n' have a committee in my head and things like that. So just like having, like inner peace, eh, trying to let all that go, which is quite hard at times. But I think the more I practise it, I even go to church, sit in church, y'know, having that peace and quiet. (Amy)

The meditation, the reason I really enjoyed it, was because I found that, when I started going to it, I used to have all this nonsense going on in my head . . . See all this stuff that I thought I had going on, before I went in there, right, when I went into meditation and I sat down, and I sat in silence, I found, I've not even got anything going on man, it's just all in your own head. So for that reason I really enjoyed it, I used to come away from it going like that, "Fucking hell man, you've not even got anything going on!" (laughs). (Mark)

Sometimes I can meditate and just be like - because I do believe the answers are all within myself just by tapping into them. For me, this is what works for me. It doesn't necessarily work for everybody but it works for me. If I can get five, ten minutes a day just to sit in quiet time just to maybe do some breathing exercise and just get that calmness that can set me up for the rest of the day. If I dinnae get that done it's kind of chaotic and kind of rushing about, my heid's

going fast and it's not very pleasant so I do try and take that time in the morning just to chill before the day starts. (Billie)

Amy was a practicing Roman Catholic and used meditation in conjunction with prayer, sometimes practising while in church. Meditation helped her to deal with the jumble of thoughts in her head and give her some peace. Similarly, Mark struggled with 'nonsense' in his head and meditation helped him to clear his mind. Billie benefited from meditation in that it helped her to calm the multitude of thoughts in her head. She also saw it as a way to find answers within herself. Another participant, Jasper, used meditation to clear his head to help him to think rationally when he may have been inclined to use substances, combining meditation with some of the cognitive behavioural skills he had learned.

7.2.2 Connecting inside and outside

As well as achieving inner peace, some participants saw meditation as a way of connecting with an inner self, God/god or the universe. This theme is suggested in the following quotes by Anna and Jasper.

So if Jesus Christ has got God within him, and I have, I'm coming to believe . . . if we've all got a bit of God within us, is that the true transparent spirit? Is that the true self? Is the words and situations we have learnt fae we were that size, polluted us? Has it taken us that far away fae the truth which is God within everybody, that we're lost, that I was lost. Because when you seek that peace, and see when I get it through meditation . . . I fall very short with it, and it's one of the best things on this earth for me, to get me closer to God, and the silence. (Anna)

With acupuncture and meditation, I feel so calm . . . It's just a really nice feeling to sit and relax and just float away and be, not worrying about anything, not thinking about anything, just to be. And whether that's at one with the universe, to let positivity come into me so that I can give it out, that I feel really calm, centred. [Jasper], just being me, I love the idea of that . . . Just feeling really one, just feeling, "[Jasper's] here, it's fine, everything's okay, and relaxed." I think with the drinking and the recovery, there's never a time to relax, and I've got to the point where now I can relax. (Jasper)

Anna made use of meditation and prayer within her Christian spirituality. She saw meditation as a way of connecting with the part of God inside her and this helped her to find peace. Anna's Christian spirituality pushes the boundaries of Christian orthodoxy and could be said to be influenced by pantheistic thought. Jasper seemed to be suggesting that he used meditation to connect with his true self and with the universe. Billie (quoted above) also indicated that for her, meditation was about connecting with her inner self. The mix of philosophies mentioned by Jasper and Billie indicate that they may have been influenced by New Age thought (Sutcliffe and Bowman, 2000). The way my participants used meditation was distinct to the way they used prayer. While prayer was about connecting with God, meditation could be about connecting with God, the universe or the true self within.

7.2.3 Mindfulness

David and Catherine, who had been involved in meditation through Buddhist centres, became disillusioned with what they perceived to be the religious elements of Buddhism. They saw mindfulness as a secular alternative to traditional Buddhist

meditation that still allowed them to develop spiritually. This is how David explained his reason for turning to mindfulness:

I've always liked the meditation and I do believe mindfulness works, I do, well I did benefit from it right. But, as I said, I'm no anti-religion now, but see everything with the religious stuff, I just felt everybody kept trying to put it on to you. So, when I found this [mindfulness group] thing . . . me and [my friend] went to it and that was my big attraction, because it was going to be improving spiritually, but it wasn't linked with any organised religion or anything. (David)

David and Catherine both seemed to benefit from the practical exercise of mindfulness on a personal spiritual level. They also seemed to gain some social benefit through practising mindfulness with others. However, they both practised at Buddhist centres and they expressed some discomfort when they met with elements of religiosity in these environments.

7.3 Spiritual reading

Spiritual reading was another personal ritual common among the participants. Most religions have religious texts, scriptures or holy books and reading them can be thought of as a spiritual exercise. The personal reading scripture is particularly important in Abrahamic religions (Judaism, Christianity and Islam). The Twelve Step fellowships also have a tradition of reading from their orthodox texts (e.g. the AA *Big Book*; Alcoholics Anonymous, 2013). Ten participants identified a habit of private spiritual reading as part of their recovery. For five, it was something they did in their early recovery to explore spiritual or religious ideas. For the rest it was an integral part of the time they set aside for daily personal spiritual practices. The following

quotes are examples of how four participants used reading as part of their spiritual practice.

Spiritual, meditation, I find myself I'll go up, I'll take a walk up [the hill] three times a week . . . I'll always take half an hour out of my day, a half hour peace and quiet, and then some readings, 24-hour book for me, and the *Big Book* and sometimes *Proverbs*. I try to read a Proverb daily. (Sean)

I read the *Recovery Bible* every night in my bed. I pick it up and just open a page. (Anna)

I had my Bible with me while I was in [treatment] and I used to read a Proverb and Psalm every day. (Ewan)

[My sponsor] got me this book called, *God Calling*. I don't know if you're aware of it? It's wee daily readings right. That was probably one of the most inspirational books I've ever had my hands on as well . . . He used to have a house group and it was to develop your kind of relationship with a higher power . . . I ended up getting everybody these books as well . . . I started reading different religious text kind of stuff, because I didn't even have a clue about the Bible and I still don't. That just carried me on a wave for a number of years. (David).

All of the participants quoted above had a Christian faith during their early recovery. Daily 'devotional' reading from the Bible or other Christian texts was common among those who had a Christian faith²⁵. Sean and Anna combined spiritual readings with prayer and meditation, while Ewan and David suggested that they also regularly used prayer at this stage of their recovery.

²⁵ Proverbs and Psalms are books in the Bible.

Twelve Step, and recovery culture more broadly, had an influence on how people read and what they read. Anna's use of the *Recovery Bible*²⁶ suggests that she sought to reconcile the ideas that she found in Christianity with recovery culture. *God Calling* (Russell, 2005) proved to be an inspirational book for David both in his personal reading and as part of a reading group. Eight participants mentioned regularly read from Twelve Step literature (published by, AA, NA or Hazelden): *Alcoholics Anonymous Big Book* (6) (Alcoholics Anonymous, 2013), *Twenty-Four Hours a Day* (1) (Walker, 2011), *Just for Today* (1) (Narcotics Anonymous, 1992), and *A Day at a Time* (1) (Anonymous, 1992). A total of six talked about reading the *Big Book* either personally or communally, however it is likely that all those who had some engagement with a Twelve Step fellowship (17 participants) read the *Big Book* in Twelve Step meetings. It is also likely that those who attended church would have read the Bible communally. The one orthodox Buddhist would similarly have read from Buddhist scriptures in the Buddhist communities that she attended.

Those who used reading in an exploratory way during their early recovery specifically mentioned the Bible, *Mere Christianity* (Lewis, 2016), the AA *Big Book* (Alcoholics Anonymous, 2013) and *The Secret*²⁷ (Byrne, 2006). Some spoke more generally about reading religious texts. Secular reading was also important to one participant as one of her recovery habits. She used 'positive readings' (positive psychology) to help her

²⁶ The *Recovery Bible* provides a recovery perspective on the Bible, including ideas from Twelve Step philosophy, e.g. Arterburn and Stoop (1998).

²⁷ A self-help book based on ideas of positive thinking and laws of attraction.

to 'change [her] negative head'. Exploratory reading proved to be influential to David and Catherine as their recovery progressed. Their material included Christian apologetics (e.g. regarding God and science) and texts from their studies in social work and counselling. They suggested that their reading played a part in them turning away from their Christian faith to agnosticism/atheism. Feminist and psychology texts proved to be especially influential to Catherine.

7.4 Conclusions

I have discussed the practice, purpose and meaning of prayer, meditation/mindfulness and spiritual reading among my participants. Prayer was an important ritual for twelve of my participants, taking on a different level of importance for each individual. Prayer habits and their level of importance varied according to stage of recovery, evolving as faith and spirituality evolved. Prayer in pre-recovery could be challenging because of perceived guilt and shame, but for some it was significant tool that brought them closer towards recovery. For those in recovery, prayer was considered to be a means of connecting with God, giving strength and a way to remain grounded in gratitude.

Meditation was important to nine participants in their recovery. Seven had been influenced by Twelve Step philosophy. Christian (3), Buddhist (4) and secular (2) form of mediation were all represented. The purpose of meditation among my participants was to bring a peace of mind and to connect with God, the universe or oneself. Mindfulness provided a secular ritual for those interested in spirituality, but wary of

religion. Only Rachel talked about practicing meditation (Buddhist) prior to her recovery. Meditation was not an important ingredient in her early recovery but she believed it helped her significantly later on (after two years). The main appeal of meditation or mindfulness seemed to be that they provided a form of spiritual practice for those with an atheistic/agnostic outlook (6).

Ten participants identified a habit of private spiritual reading as part of their recovery. My participants had different reasons for reading during their recovery. Some used reading to explore new idea, or to find positive ideas to replace the negative ones that had typically dominated their thoughts. Some of them perhaps were looking for truth or meaning in what they read. Those who made spiritual reading a part of their daily routine may have been looking for inspiration and cognitive grounding to get them through the day. It is likely that for those reading the Bible there will also have been a devotional aspect – a means, combined with prayer or meditation, to understand, know and connect with God. There was also some suggestion that those who were reading positive psychology and non-religious texts were trying to find or connect with their true selves. In reading the Bible, the *AA Big Book* and other communally read texts there may also have been an effort to gain social capital in the form of knowledge with the aim of being associated with and more connected with a community of ‘believers’.

While I have presented prayer, meditation/mindfulness and spiritual reading in separate discussions, many of my participants practised one, or several rituals

together, as part of a routine ritual practice. For some individuals, these routines also incorporated less common alternative rituals, namely, Tai Chi, Qigong, acupuncture and reiki. Participants practised their spiritual rituals in various routines – e.g. daily, three times a week, weekly etc. Routines tended to be more intense in the early stages of recovery. Routine ritual practices are commonplace in the Christian and Buddhist traditions. They are also encouraged in the Twelve Step tradition, as indicated in Step Eleven:

[We] Sought through prayer and meditation to improve our conscious contact with God as we understood God, praying only for knowledge of God's will for us and the power to carry that out (Alcoholics Anonymous, 2013).

Establishing a daily routine can be very important to a person in recovery, and especially in early recovery (White, 1996). Lifestyles of problematic substance use are defined by routine rituals that typically involves finding drugs, using drugs, getting money to buy drugs (often through crime), trying to stop using drugs, interacting with treatment services and the criminal justice system etc. Part of recovery is about changing these habits and establishing a substitute routine. The daily practice of spiritual rituals can be part of such a routine. Seventeen participants had some kind of routine spiritual practice, ranging from a brief prayer, sessions of prayer, meditation and spiritual reading, to prolonged meditation sessions. As well as offering practices for a routine, spiritual rituals may facilitate meaning-making and emotional resilience (Laudet et al., 2006; Pardini, et al., 2000). The routine nature of spiritual practices for many of my participants should already be evident from what

has been described above. The following two examples emphasise the point. I have already illustrated how Sean had a daily practice of meditation, prayer and spiritual readings. He goes on to make the point that he is on a daily programme.

I'm just basically on a programme the day, you know, basically handing all my care over to my higher power in the morning, and say my prayers and do my readings and that, fae AA . . . But I just know, I've drummed into myself that if I take the first [drink or drug], that's the slippery slope, isn't it? I do say the *Serenity Prayer* a lot, I just find that beneficial to me. I've got a *Just for Today Card*²⁸ as well. (Sean)

Sean had a Christian faith and attended a Pentecostal church. He was also involved in AA and CA and seemed to have picked up his daily spiritual programme, or routine, mainly from the Twelve Step fellowships. Sean believed that having a disciplined spiritual routine helped him to stay clean and sober.

Mark also had a routine of spiritual practices that he picked up from NA. In contrast to Sean, Mark had no belief in a higher power. At first he was resistant to the spirituality he encountered in NA but he eventually learned to use the spiritual practices in his own way:

Aye, I've got my own wee kind of ways that I go at it every day. I get . . . like we were talking at the beginning, like your belief systems, and what like my belief systems used to be to what like they are the day. Like people who prayed and all that, I just don't, I was like, "You're idiots", you know what I mean? But I wouldnae leave the house without praying now. And I've got my books, I've

²⁸ A card produced by Alcoholics Anonymous consisting of maxims for daily living, based on Twelve Step philosophy.

got a *Just for Today* book that I read every day as well. So I'll read that, and then I'll say my wee prayers that I say every day. And for that, that's some change, know what I mean, for me. And I done a wee bit of, for about a year as well, I went to meditation centre every week, I used to go to that as well. And I really enjoyed it, but I ended up, when I started working and I started getting a lot busier, and I kind of fell away from it, but I really enjoyed it. (Mark)

Mark used prayer, spiritual readings and meditation (for a time) as secular practices.

He was not trying to connect with a higher power. Mark's example suggests that the routine practice of spiritual rituals can be beneficial even if the person has no sense of connection with a higher power. Sean's and Mark's use of spiritual rituals emphasize the point that such routine practices can be beneficial to a person in recovery. The repetition of rituals reinforced their new recovery lifestyle and, as will become clear in the subsequent chapters, helped them to construct meaning and reinforce their recovery-orientated identities.

8 Integrating beliefs in recovery (1): Constructing meaning

In the next two chapters, I will address my final research question, ‘How do individuals integrate beliefs in recovery?’ The previous chapters began to answer this question in terms of how individuals construct personal belief systems (Ch. 5), and how they put their beliefs into practice (Ch. 6, 7). In the following two chapters, my aim is to delve deeper into how individuals make use of beliefs in recovery within an integrative personal belief system. In this chapter I will explore how my participants integrated beliefs into their understandings of fundamental recovery experiences, in terms of constructing meaning. In chapter nine, I will consider how they used beliefs to construct, or reconstruct, recovery identities.

Recovery is a complex process that consists of physical, psychological and social experiences. For most people, recovery involves incremental change (White and Kurtz, 2006), and may involve going through various psychological steps or stages of change (Frykholm, 1985; Waldorf, 1983; DiClemente and Prochaska, 1998). Others experience dramatic transformational events in their recovery, which inspire them to stop using their problematic substances. These experiences have been referred to as a *quantum change* (Miller and C’de Baca, 1991), a *rock bottom experience* (Maddux and Desmond, 1980), a *brief developmental window of opportunity* (White, 1996), a *crossroads* (Klingemann, 1992), an *epistemological shift* (Shaffer and Jones, 1989) and a *radical reorientation* (Frykholm, 1985). Such events can take on religious, spiritual

or secular meaning. Transformational experiences are common in Twelve Step narratives, e.g. Bill Wilson's conversion experience (Wilson, 1962).

The events that contribute to a recovery journey only have an impact on a person's recovery if meaning is ascribed to them. Meaning-making is a fundamental aspect of human life. The stories and reflections on their experience of recovery that the participants shared with me were infused with meaning. It should be acknowledged, however, that the meanings that were communicated in the research interviews were removed from the meaning-making performed at the time of the events that the participants recounted. The retelling was affected by memory, imagination and the altered perspective of hindsight.

Victor Frankl was one of the first modern authors to suggest that having meaning and purpose in life is a core aspect of what it means to be human (Frankl, 1992). This notion has been supported and developed in subsequent psychological and social science literature (Klinger, 1977; Maslow, 1968; Baumesiter, 1991; Baumesiter and Vohs, 2002). It has been suggested that religious belief and practice can be an important source of meaning making (Fowler, 1981; Pargament et al., 2005; Klemke, 2000). Religion, spirituality and existential meaning can help an individual cope with health problems, stress or traumatic life events through providing meaning (McIntosh, 1995; Park and Folkman, 1997; Mascaro and Rosen, 2005; Park, 2005, 2013). Specific research also points to the importance of finding meaning and purpose in recovery from problematic substance use, especially through religion and

spirituality (Carroll, 1993; Waisberg and Porter, 1994; Gorsuch, 1995; Laudet et al., 2006; White et al., 2006; Oakes, 2008; Martin et al., 2011). Laudet et al. (2006) sum up the potential benefit of finding meaning in recovery, especially through religion and spirituality.

Spirituality, religiousness and life meaning enhance coping, confer hope for the future, provide a heightened sense of control, security and stability; they confer support and strength to resist the opportunity to use substances, all of which are very much needed to initiate and maintain recovery . . . While not all recovering persons embrace spirituality/ religiousness, many report that a spiritual or religious connection to the transcendent is part of their recovery . . . Life meaning helps transcend the here and now, re-establish hope and the ability to cope . . . this is particularly important for recovering individuals who may face painful and difficult realizations about the destructive consequences of their past use on their life and that of their loved ones, in addition to the difficulties they are encountering in the present (58, 63).

Telling stories may be important for individuals in constructing meaning and their own identities (see Ch. 9) (McAdams, 1993; Maruna, 2001; Singer, 2004). In interviews with the participants – through asking and answering questions, through story-telling, through reflecting – my participants and I were involved in a process of constructing meaning. My participants shared a number of different types of experiences that were important to their recovery stories. Individuals used their personal belief systems as meaning-making frameworks to interpret these experiences. Types of experience included: dramatic transformational experiences that marked the beginning of abstinence; developmental experiences that helped individuals move forward in recovery; occasional experiences of enlightenment that were sustaining moments in recovery; experiences of transcendence (or

hallucinations) linked to intoxication or detoxification from substances; and spiritual experiences in the context of mental ill health. I will discuss each of these types of experience in turn and reflect upon them further in the concluding section.

8.1 Dramatic transformational experiences

Two participants talked about having acute experiences of crisis that they interpreted as interventions from the Christian God. These became transformational spiritual experiences in their recovery, resulting in lasting change. Sean's transformational experience happened in the context of years of failed attempts to change, involvement with numerous treatment and support services (e.g. psychiatric addiction services, AA) and serious deterioration of his physical health. On this occasion, Sean's heart stopped after a session of heavy drinking and he was revived by medical staff in a hospital. Looking back he believed that before his near-death experience he was 'spiritually dead'. He had had enough of his drug-centred lifestyle and had gained acceptance that he had the 'illness of alcoholism and addiction'. Reflecting on the experience he said,

For better or worse I'd say it was a spiritual experience as well, because I was tending to go to the [Pentecostal] church . . . a wee bit before that . . . I was at [the] church where I let Jesus Christ into my heart. (Sean)

Sean explained that since his near death experience he no longer had any desire to use substances. He described this as a 'miracle'.

David had also reached a point in his life where he felt he had had enough of using drugs. He said that he had reached 'probably the lowest point' in his life. In response to these feelings he made plans to take his life. David took steps to hang himself in his flat and had written a final letter to his mother. Earlier that day he had phoned his mother to check if his brother was coming to visit him. His mother had told him that his brother was not coming. The subsequent events marked the beginning of David's abstinence from psychoactive substances as he recounts in the following.

So, I had wrote this letter and I had planned to do it a certain time, and I really do believe I would have done it right. My maw phoned me and said, "Listen, [your brother's] coming through," right. See before that, it's the first time I think I ever sincerely prayed in my life, right . . . I was asking for forgiveness and all that right, and it's probably, now I just see it as all coincidental and it was because my mum realised something was far wrong that she'd - I think she had fucking probably put a knife to my brother's throat and said, "You better get through there" (laughs), right. But, at the time, so I was praying, and I was like that, "Forgive me for this, I cannae dae it," and di, di, da, and I'm no just saying that, about ten minutes later the phone went and it was my mum, she said "[Your brother's] on his way through," do you know what I mean? So, I put that down right, to God, right, and it's bizarre what happened. It was a Damascus Road experience, and it was the most profound thing that's ever happened to me in my life. (David)

At the time, David interpreted the second phone call from his mother, and his brother's timely visit as an intervention from God. Immediately afterwards, David gave all his prescribed methadone and diazepam to friend who lived nearby. His brother came through that evening and the next day David went to NA. Despite ending up in hospital due to withdrawal symptoms, David said he never used illegal drugs or alcohol again. As a result of his experience David developed a Christian faith

that centred around his involvement in NA, his relationship with a Christian mentor and involvement in a higher power group.

8.2 Developmental experiences

A number of participants recounted having spiritual experiences that were important to their recovery narrative. These experiences had an impact on how an individual's spirituality developed and how their recovery progressed. The experiences were interpreted as spiritual in that they involved some kind of transcendent sensory and/or emotional experience. In the following paragraphs I highlight examples from two participants. The examples incorporate Christian spirituality and Twelve Step spirituality.

Ewan talked about having several spiritual experiences before abstinence and during his early recovery. These experiences were linked to the development of his Christian faith. (He used 'spiritual' rather than 'religious' to define these experiences). The first spiritual experience that he linked to how his recovery developed was when he was evangelised by two Christians. On this occasion, he prayed and he 'felt something'. He described it as, 'like, a peace and glow, you know, it was tangible'. Whatever Ewan actually experienced on this occasion (a spiritual encounter or a purely physiological reaction), Ewan chose to embrace a Christian belief system and used it to make sense of what he felt. While Ewan's conversion to Christianity did not seriously affect his drug use at first, his faith gradually became foundational in the development of his recovery and helped to sustain his recovery.

Ewan shared another spiritual experience that was an important step towards his long-term recovery. It happened when his family came to visit him to try to get him to go to rehab. His aunt, who also had a Christian faith, asked him to play a Christian hymn on his guitar.

So I went, got my guitar, came back and it was that old song *Just a Closer Walk with Thee*. As I started playing that, I could feel my bones for it again. And I was, you know, God just answered my prayers. I just put down the guitar, started to cry and just said, "I'm coming home". (Ewan)

Ewan was in the habit of praying for God to help him overcome his problem with drugs and he interpreted his family's intervention as an answer to prayer. This was confirmed for Ewan in the emotional/spiritual connection that he felt. Again, Ewan used his Christian belief system to make sense of his experience. Ewan shared other spiritual experiences which were integral to his how his recovery story developed. These experiences contributed to his strong sense of Christian identity (see Ch. 9) which motivated him in his recovery and gave him a meaning framework, personal rituals and community resources to help him build and sustain his recovery.

Anna's recovery began at a time when she had already made many attempts to stop using drugs. Her sense of hopelessness was compounded by the death of her ex-partner from a drug overdose and shortly afterwards she planned to take her life. Instead of going through with her plan she found herself phoning a helpline to find out about a local NA meeting. Her first experience of NA was emotionally powerful. Looking back, she interpreted her experience as God reaching out to her.

It was such a beautiful gesture, you know (crying). She just gave me her number really, which is really quite a small action, it was such a beautiful gesture and it just felt like something very powerful to me. And in the AA *Big Book*, there's a bit in it that says, "What we thought at first it was a flimsy reed turned out to be loving and powerful hand of God." And that's always . . . every time I think of that gesture I think of that bit in the [*Big Book*]. Because my life totally . . . when I went to that place, Peter, my life totally turned around. It was the beginning of the end really. You know, it was a different thing that was happening. (Anna)

8.3 Transcendent/hallucinogenic experiences

A number of participants talked about having transcendent experiences in which they saw, felt or heard unusual things. One of these experiences happened while the individual was still detoxing from drugs, while another person was just recently clean. These cases illustrate the complexity of explaining spiritual experiences when psychoactive substances are involved (e.g. Moro et al., 2011).

Ewan brought up the topic of having spiritual experiences while using substances. When he was describing his first 'Christian' spiritual experience, he talked about feeling a peace and glow that was tangible. He then explained how he reacted to this experience.

The weird thing is, what did I dae? I phoned up another addict and just said, "This weird thing's happened to me." And then I went and got drunk. And, so it was a spiritual experience, you know . . . 'cause I now know there's a difference, you know, 'cause I had spiritual experiences, you know, (laughs) when I using magic mushrooms. Definitely, you know, like an experience of a creator God, you know, but . . . or maybe that was a sensational, you know, whatever what it was, a physical sensation. I would go to church. I was really quite involved in the church. (Ewan)

Ewan wanted to stress the tangible nature of his first Christian spiritual experience, yet he also had sensing experiences of a creator God whilst using drugs. Ewan's action of getting drunk after his spiritual experience illustrates firstly, that spiritual experiences do not always motivate recovery orientated behaviour, and secondly that there can be a blurring of boundaries between the ways in which drug users can seek transcendence, peace or pleasure.

After Ewan's spiritual experience during his family's intervention, he returned home and began a home detox while he waited to enter rehab. It was at this time, which was over the Christmas period, that he had a transcendent vision.

I remember - this is the weirdest thing. Then I had to tell people this and think, if you're no spiritual, they'll think you're off your head. Well, 'cause it was Christmas, well, near Christmas time. My sister-in-law had the Christmas [decorations out] . . . There was an angel, a wee glass jar thing, and when I would start to pray, when the rattles, when I couldnae sleep, started flashing and I tried turning it off one time 'cause it was annoying me. You know, I was catching the corner of my eye. And I said to my sister-in-law . . . I says, "How do you get the batteries oot that?" And she said, "There's no batteries in there. It's no worked for years." You know, when - God was with me when I was praying. You know, but (blows out) . . . Aye, this angel would light up. This Christmas decoration, you know, that hadn't worked in years. But [my sister] had always took it out, because it was part of tradition, "Get the angel out," you know. I decided, "Right, that's it. I'm going to [rehab]." No, I thought, "I'll give it a try." (Ewan)

Rationally, one might think that Ewan was having a hallucination as his body chemistry adjusted to detoxing from drugs. However, Ewan interpreted the experience through the framework of his Christian faith. He seemed to take the event

as confirmation from God that he should go to rehab. In this sense, it had a positive impact on his recovery.

Anna spoke at length about her substance use, using language that suggested a spiritual experience. When she talked about using alcohol for the first time as an eight-year-old, she talked about it giving her a feeling of 'absolute safety'. She explained that she constantly sought this feeling in using different kinds of drugs. She felt this sensation more intensely when, while in hospital, she was given diamorphine.

I felt that I was in heaven and I thought I would just like to die now. I remember thinking that. I just want to die now. Quite happily, and not in a sad way, Peter, I don't remember feeling sad. It was more like (blows out) this is what I wanted. Here it is, this is what I was looking for . . . It was a peace that I had always sort of felt that I . . . that feeling when I was a wee kid when I took that drink. Oh, but it was so much more intensified. So much more like . . . "I don't need to do anything else, I'm finished here . . . Can I just go now?" That, I remember that sorta thinking, you know. (Anna)

On first appearances, it seems that Anna is describing simply a physical and emotional experience, rather than a spiritual one. However, she elaborated on her perception when she discussed how she continued to seek this sensation.

I would go drinking alcohol at half seven in the morning before I got the weans up for school just so I could get that feeling that I got in the hospital. That feeling I got when I was eight. That feeling of connectedness, you know just being connected to the universe, being connected to God. Now, that's what I feel it was; that seeking to just feel that peace. But I suppose in a way I've sought that all my life for as far back as I remember, just because never having that peace, never being able to express myself, always putting a face on. (Anna)

During her recovery, Anna developed a spirituality linked to her idea of the Christian God. Though she did not state it explicitly, it could be argued that she shifted the focus of her quest for safety, peace and connection from drugs to spirituality and religion. She had started to attend NA and had enrolled in an out-patient recovery programme where she was supported to detox at home. Five days after she became clean she had an intense transcendent experience.

I was lying curled up in a ball, terrified - "I'm not going to get through this. I will lose my sanity now and I'm clean now. I'm five days clean." You know, and I remember lying there, I was crying, and I remember saying out loud "Please help me." And it was like - this is the only way I can describe this, Peter. It was like the most gentlest, kindest, softest thud within my very being, out the way. Fae my soul it felt like, out. It was like, a gentleness and a heat that I have never experienced. And I heard, I felt these words within my being - "I am the way, the truth in my life." Bang (clicks fingers), my mind stopped like that. I got a fright. "What's happening? What is happening to me here?" And I fell asleep. I fell asleep. (Anna)

Anna went on to recount how, following this event, she slept better than she had in a long time. The next day she said that everything appeared stark, fluid, strange and raw. Then she described how she perceived her daughter.

My daughter . . . walked into the living room and I gasped out loud and cried. I could see how beautiful she was, her beautiful blue eyes and hair, I could see all the wee light bits where the sun had lightened her hair. She just looked like a different being. And I got a fright. (Anna)

Anna continued by describing how, after going outside, everything she saw appeared more vivid, fluid and profound. She continued by describing how this experience impacted her.

I felt like a different person (laughing). I just feel different. I know now, I have this clarity of thought. I know, that I can't use drugs again at that point. And people say to me in the fellowships be careful of saying that because we only have "just for the day," which is fair enough. But something within me knew, "This is a new life for you, [Anna]. This is going to be different. This is it. This is the change, embrace it and go with it." Do you know what I mean? That's why I've worked so hard in the last four years of my recovery, Peter. (Anna)

What Anna experienced was profoundly emotional and in her eyes, spiritual. Anna was not a religious person previously, but her use of prayer and her recollection of the Bible text indicated that she had had some exposure to Christian culture. Regardless of how one might explain what Anna experienced, it is clear that it had a positive impact on her recovery. She said she felt like a different person and saw the experience as the marker of a new life for her. The spiritual framing that Anna embraced, bolstered by the emotional and sensory elements of her experience, gave her a new hope for her life and the possibility of establishing a new identity. Following her spiritual experience, she began to explore the Christian faith through attending various churches and she also developed her spiritual identity through practices of meditation. She expressed that she sometimes struggled to know exactly what she believed, yet her spiritual beliefs and practices became important resources in the development of her recovery.

8.4 Moments of enlightenment

Seven participants expressed what I understood to be 'moments of enlightenment' in their experiences of recovery. They had a sense of seeing things through a new

light, appreciating life, and especially nature. It was something that was often experienced during the early days or weeks of abstinence and it was often, if not always, interpreted as a spiritual experience.

Anna's spiritual experience, as shared above, is an example of this. She described how she saw things through a different light. Everything became more vivid, profound and beautiful (not unlike the Biblical story of Christ's transfiguration²⁹). Her heightened sensory perception was also accompanied by a 'clarity of thought'. The following selection of quotes, illustrates how other participants had different kinds of enlightenment moments.

[Recovery is] being able to look at myself and have a laugh, being able to appreciate nature, all these things. Being close to nature, just living and being able to smile . . . I don't know if it's been a spiritual awakening, I just know sometimes when I get maybe a deeper level of consciousness the world can seem a lot lighter and brighter and that can last for a wee while. It restores my faith so it helps me keep on going. (Billie)

[I think my recovery started] when I was on the Suboxone, actually, I think, d'you know, I was feeling a lot better, the clarity and that was there, d'you know - I could see things clearer . . . It feels like I was gaun about wi' my eyes shut for all they years, and it's like, getting clean and all that, it's like, oh! D'you know what I mean? Noticing stuff, an' a' that, and it's amazing. Aye, it's like being reborn! . . . At some point I've been on a bus, and been, just, sort o', looking about me, and having to take a deep breath because I was, sort o', in awe o' just everything I was seeing - d'you know

²⁹ The Bible: Matthew 17:1–9, Mark 9:2–8 and Luke 9:28–36.

what I mean? I don't know if that was . . . some folk in NA said that was a spiritual awakening! I don't know. I don't know. (Alison)

You can smell flowers and you think, I never used to notice these things before. (Nina)

There is humbling moments. Where I've been out there on my own and that, you've got to take my word for this, you know it's like "Wow," is just the way the sun moves down, or bits of wildlife, coming across, that's just, and it does feel borderline spiritualish, but it's just humbling moments, I'm trying to hold onto these as that you know, you eureka moments if you want to call them that. (Matt)

I suppose, for me it's like, my first spiritual experience was probably putting the drugs down and getting my first day clean. You know like, you can walk about now with clearer eyes. I can have a moment looking at a tree (laughs), d'you know what I mean? Just seeing things through a new light, it's just like you've awoken, and you're seeing things through a different light. (Amy)

Some participants identified particular incidents of enlightenment when they had a heightened sense of clarity. Anna's account is a clear example of this. For others it was something that happened from time to time. Billie suggests this in her comment and Alison, after describing her experience on the bus, said her experiences of awe happened a lot. She thought that this was probably about being clean. Both Alison and Matt had a secular perspective.

8.5 Mental ill health and spirituality

All but one participant mentioned that they had experienced some kind of mental health problem linked to their problematic substance use. Several talked in general terms about their mental health being affected by their drug use. Others mentioned

suffering from particular issues. These included depression (8), suicidal ideation (8), attempted suicide (4), drug induced psychosis (2), paranoia (2), nervous breakdown (2), post-traumatic stress disorder linked to sexual assaults (2), hallucinations (2), bipolar disorder (1), and eating disorders (2). Three made specific mention of being admitted to a psychiatric ward for their mental ill health. Many of them had multiple mental health issues. One particular case in my research highlights the challenge of understanding spirituality when taking mental ill health into account (e.g. Oxman et al., 1988). It also links to the theme of substances and interpreting spiritual experiences as discussed above.

Olly dabbled with various drugs but alcohol was his main problem. He had an essentially secular upbringing and, as a young man, thought of himself as an atheist. The only religious element in his upbringing that he mentioned was an awareness that his Nan was Roman Catholic. Olly seemed to develop a sense of a spiritual dimension through his struggles with his mental health. During his early to mid-twenties, Olly suffered from a combination of paranoia and hallucinations (internal voices) during the short periods when he was sober. Olly was admitted to psychiatric wards on several occasions for his condition. He said his condition was 'mostly undiagnosed' but he suggested that it was drug induced psychosis. While he was aware that his symptoms may well have been the side effects of his substance use, he also had a strong sense that the voices that heard were real, as he explains in the following:

I'd had a few experiences . . . of like, well, being convinced that the devil, the devil, I was speaking to the devil, or at least dark forces, em (laughs), quite a few times. I'm not a hundred per cent convinced that I wasn't, actually. (Olly)

Olly believed that the voices that he was hearing in his head were spiritual beings of some sort. He shared a specific example which he said was probably his worst experience.

At one point . . . I was actually following this – I decided, “Right, I’m just going to face whatever this power is, I’m just gonna go to wherever they tell me to go and let them just do what they want to me.” And so I was led around [the city], as real as anything could ever be, for about six, seven hours. And the voices kept saying, “Don’t drink. We want you to feel all of this.” It was, it was pretty dark. And so, I just did that. Obviously I’m physically withdrawing . . . At the time, I can see I was probably hallucinating . . . This was real. And I was convinced that I was getting led to my death. And there was these kind of, eh, I don’t know if necessarily supernatural, but maybe I was just, I had just kinda been, been awoken to the reality that was like, eh, just these beings, these people that had been focusing on me for this whole length of time and regarded me as this like scum of the earth that needed to made an example of kinda thing. Very eh, (laughs) self-obsessed. (Olly)

Olly personified the voices that he was hearing in his head as spiritual beings. They were telling him not to drink and he thought that this meant that they despised him, and they wanted him to suffer and ultimately to die. Olly was torn between thinking that the voices were an hallucination or that they were part of a supernatural reality.

Olly’s framing of the voices that he heard as supernatural may have been influenced by a general awareness of ideas from religion and spirituality in society. Olly had had some periods in Christian rehabs which certainly influenced his subsequent outlook.

He had a very brief residency at a Christian recovery community in Scotland. After a four-month binge he went to a Christian rehab in England which he thought of as 'the last chance saloon.' This is how he described it:

I went in there and it was really strict. It was sort of hammering into us . . . It was great. Kind of got well, physically, and I did a lot of praying, I read a lot of literature, a lot of Christian literature.
(Olly)

Olly stayed in the rehab for about six months. He left because he wanted to drink but in terms of his recovery, he felt that the workers there were 'getting closer and closer to the truth.' Before entering the rehab, he had already had experiences of hearing voices and believing that it was the devil or dark forces speaking to him. Afterwards he continued to have them with increasing intensity. Following the experience described above Olly was admitted to a psychiatric ward and then returned to the Christian rehab for a short time. Olly suggested that his paranoia and sense that he did not 'deserve' to recover contributed him to leaving on this occasion.

I was convinced that God, obviously being the most powerful, had sort of ordained all this, that I did deserve what I was getting, and what was coming, and everything that had happened in the past. And that he certainly didn't want me sober. (Olly)

While the voices that Olly heard told him not to drink, their message was overtly negative. They contributed to thoughts and feelings of inadequacy, guilt and self-hate, leading Olly to return again and again to drugs for respite. The catalyst for Olly's recovery was attending an abstinence-based rehabilitation programme which drew heavily on Twelve Step ideas and practices. Part of this approach was encouraging

clients to develop a relationship with a higher power. Olly's recovery became grounded in attending Twelve Step groups, praying to the God of 'his understanding' and reading *A Day at a Time* (Anonymous, 1992). His sense of connection to his God was core to his recovery.

Olly was the only participant who shared overtly negative spiritual experiences, apart from the negative perceptions of religious doctrine and practice that some had described. Even though he had these negative experiences, he was able to use spiritual belief and practice as resources in his recovery. Olly's example highlights the complexity of making sense of spiritual beliefs and experiences when substance use and mental health problems are involved. Hallucinations are a recognised symptom of alcohol withdrawal (delirium tremens; APA, 2013). Olly's negative spiritual experiences could be interpreted as cognitive malfunctions from a purely naturalist perspective. From a theological perspective, it could be suggested that his spiritual perception was both heightened and confused by the effects of drug use and mental ill health.

8.6 Conclusions

In the research interviews, my participants described having physical and emotional sensory experiences that often had a positive impact on their ability to recover. In many cases these were interpreted as spiritual or religious experiences. While I am open to the substantive reality of such experiences the limitations of social science do not allow us to say whether or not these experiences involved some interaction

with spiritual being/s or forces. For the participants, some were convinced that these were real spiritual encounters, while others wavered in their convictions. David, for example, in looking back on his transformative experience, doubted that it was an encounter with a real God.

I argue, therefore, that each person interpreted their experiences through the lens of their personal belief system. Irrespective of what was happening to them at the time (physically, emotionally, mentally or spiritually), they used their personal belief system to make sense of their experience and give it substantive meaning. In some cases, this was a way of coping with stressful or traumatic situations – Sean’s brush with death; David’s depression and suicidal ideations; the tension Ewan felt between his desire to continue using and family pressure to go to rehab; the pressure Anna and Olly felt to stay clean. Finding a new sense of meaning and purpose in life may be particularly important when one is faced with a life or death choice. Sean’s framing of his resuscitation as a miracle, and spiritual experience, is perhaps unsurprising since he had been occasionally attending a Christian church around the time. David’s adoption of the Christian God is more remarkable as he had little previous connection with Christianity and had only vague ideas about God.

Ewan and Anna used their spiritual and religious beliefs to make sense of developmental moments in their experiences of recovery. These experiences were important to their recovery narratives and how they made sense of their recovery. Ewan chose to interpret the intervention of his family and the emotion that he felt at

the time as an answer to prayer and a spiritual experience. Anna's telling of her story about her first experience at NA suggested that it was only with hindsight that she interpreted it as a spiritual experience, using the language and theories that she had learned through Twelve Step groups (e.g. "What we thought at first it was a flimsy reed turned out to be loving and powerful hand of God"). Reframing this experience through her evolved personal belief system gave the experience deeper meaning. The meaning that Ewan and Anna ascribed to their stories may well have been reinforced through their telling and re-telling of their stories.

The experiences of transcendence shared by Ewan and Anna highlight the complexity of interpreting spiritual experiences when substances are involved (Moro et al., 2011). Ewan expressed this when he referred to having an 'experience of a creator God' when intoxicated, saying, 'or maybe that was a sensational, you know, whatever what it was, a physical sensation.' Ewan and Anna also both recounted having spiritual experiences when they were detoxing from substances (including alcohol and opiates). Sensory perceptions may well be affected during detoxification as the body and brain chemistry makes adjustments (e.g. delirium tremens; APA, 2013). Alternatively, some have suggested that substance use opens a sensory gateway into the spiritual realm (Huxley, 2004; Leary, 1969). Ewan already had a strong Christian belief framework, allowing him to interpret his experience as a sign from God. Anna's situation was different as she had no particular spiritual belief at the time, yet she also interpreted the experience as an intervention from the Christian God. The experience seemed to be foundational in the development of her spirituality. Telling

this story as part of her recovery narrative also gave her recovery meaning and reinforced her sense of spiritual identity.

Moments of enlightenment were a common experience for several participants. The occurrence of moments of enlightenment among people in recovery suggests a type of mental, emotional, sensory and/or spiritual awakening. Using substances with a depressant effect means the impairment of cognitive function and the prolonged use of such a substance can lead to temporary or permanent cognitive impairment (Bowen and Larson, 1993). As a consequence, long term heavy use also impairs emotional development. While stimulant or hallucinogenic substances may heighten perception in some senses, the prolonged heavy use of such substances leads to tolerance, the diminishing of such effects and depression or psychosis can follow. In other words, long term heavy drug use has the effect of clouding cognitive and emotional perception. When a person stops using, they soon (depending on the drugs involved) start to see things unimpaired by the effect of drugs. In this sense they awake and have a sensation of being reborn and they start to notice the beauty of the world around them, perhaps with senses heightened beyond those of the average person.

The reported moments of enlightenment ranged in intensity and impact. The experience Anna shared seemed to have a profound impact on her recovery and spirituality. Others had occasional experiences that gave them a general sense of wellbeing. In all of the examples there were references to noticing the beauty of

nature. These experiences were interpreted in different ways. Matt had a secular perspective and resisted defining his experiences as spiritual. While he referred to his experiences as 'spiritualish,' he preferred to frame them by drawing on a scientific metaphor - 'eureka moments'. Alison also had a secular perspective and was hesitant to believe that it was a 'spiritual awakening' as suggested by her friends in NA. However, she drew on the religious metaphor of rebirth to make sense of her experience.

Those who had adopted a spiritual belief framework also made use of the Twelve Step metaphor of spiritual awakening to make sense of their experiences. Billie and Alison suggested that they might have been experiencing a spiritual awakening, yet neither was sure about this. Anna also drew on the metaphor to interpret and explain her experience. She compared her experience to the spiritual awakening of Bill Wilson in Winchester Cathedral (Alcoholics Anonymous, 2013).

I have discussed the difficulty in interpreting fundamental recovery experiences when substances are involved. Things are further complicated when mental ill health is involved. Olly's example illustrates this. Olly could not be sure in his own mind whether the voices that he heard were substantive spiritual beings or hallucinations that came from his mental ill health. His framing of the voices as being the devil or dark forces, ordained by God, suggests that his perception was influenced by his knowledge of Christian culture. His time in Christian rehab seemed to emphasise this framing. This may suggest that some aspects of or approaches to Christian teaching

could be a negative influence upon people suffering from mental ill health. Whatever the negative effects of religious teaching on Olly's experience, he eventually adopted a spiritual framework that became a positive resource in his recovery.

My participants used their personal belief systems to give meaning to their experiences of recovery. In many cases this meaning-making process involved attributing purpose and hope to otherwise apparently meaningless, desperate situations. The process of meaning-making was facilitated through engaging with belief-orientated communities and practising personal rituals. Meaning-making is further integrated into a person's personal belief system through the process of identity construction, the topic of my next chapter.

9 Integrating beliefs in recovery (2): Constructing Identity

As a first step to answering, ‘How do individuals integrate beliefs in recovery?’, in chapter eight I outlined how my participants used their beliefs to construct meaning during significant moments in their recovery. In this chapter, I answer this question by focusing on processes of identity construction.

The concept of identity has been used in sociological and psychological literature and has been theorised in various ways (Weigert et al., 2007). Common usage of the concept refers to one’s conception of self in relation to others, or as Berger (1966) observes: ‘One identifies oneself, as one is identified by others, by being located in a common world’ (111). Theorists have categorised identity in different ways. Onorato and Turner (2004), for example, distinguish personal identity from social identity, within a framework of self-categorisation theory:

Personal identity refers to ‘me’ versus ‘not me’ categorizations—all the attributes that come to the fore when the perceiver makes interpersonal comparisons with other in group members. Social identity, on the other hand, refers to ‘us’ versus ‘them’ categorizations—all the attributes that come to the fore when the perceiver compares his or her group (as a collective) to a psychologically relevant outgroup (259).

Within the sociological tradition of symbolic interactionism, it has been assumed that identity reconstruction is necessary for exiting a ‘deviant’ lifestyle (e.g. Goffman, 1963; Becker, 1973; see Anderson, 1993 for an overview). The evidence-base

suggests that this theory applies to recovery from problematic substance use (Waldorf, 1983; Biernacki, 1986; Stall and Biernacki, 1986; Shaffer and Jones, 1989; White, 1996; McIntosh and McKeganey, 2000, 2002; Larkin and Griffiths, 2002; Best et al., 2011). Biernacki (1986), in perhaps the most commonly cited pioneering study, proposed three main types of identity transformation based on his research among individuals who recovered without treatment. Within the framework of 'becoming and being ordinary', he identifies: emergent (new) identities; reverting to unspoiled identities; and extending identities that remained intact during the addiction (179). Within a symbolic interactionist framework, identity reconstruction is fundamentally social. It is socially bestowed, socially sustained and socially transformed (Berger, 1963). This notion is supported by Biernacki (1986):

A successful transformation of identity requires that availability of identity materials with which the nonaddict identity can be fashioned. Identity materials are those aspects of social settings and the relationships (e.g. social roles, vocabularies) that can provide the substance to construct a nonaddict identity and a positive sense of self (179).

The construction of identity through social networks has been the focus of more recent research on recovery and identity (Koski-Jännes, 2002; Buckingham, Frings and Albery, 2013; Mawson et al., 2015; Dingle et al., 2015). It has also been proposed that re-constructing one's identity through constructing a new narrative of self is an important process in recovery (Cain, 1991; Etherington, 2006; Weegman and Piwowoz-Hojort, 2009; Irving, 2011; Strobbe and Kurtz, 2012; Dunlop and Tracy, 2013). Relevantly, some research considers how forming a new religious or

spirituality identity can be part of this process (Engelbreght, 2011; Sremac and Ganzevoort, 2013a, 2013b; Sremac, 2010)

Among my participants it was evident that constructing a new identity was at the heart of their recovery. During their phase of problematic substance use, most participants talked about having a negative self-perception. Catherine, for example, specifically talked about having a 'deviant' identity. Recovering involved either returning to a former idealised sense of self, or establishing a brand new sense of self ('reinvention' as Rab called it). In the early stages of recovery this involved identifying oneself as a problematic drug user (alcoholic or addict). This often involved social identification with a group of other people in recovery, such as AA, NA or SMART recovery groups. As recovery progressed, constructing a new identity involved nurturing positive values (such as forgiveness, tolerance, kindness etc.), establishing positive habits or rituals and integrating with healthy communities. In later recovery, the individual would sometimes (but not always) identify themselves as having recovered or being an ex-addict or alcoholic (their post-recovery identity). The main types of identity construction or re-construction that I identified among my participants were: reconnecting with a childhood religious identity; re-constructing a religious/spiritual identity; establishing a religious/spiritual identity; discovering a new religious/spiritual identity; discovering a non-religious spirituality; and assembling secular identities. I will proceed by looking at each of these in turn. It will become evident that there is overlap between the types of identity construction that I have delineated.

9.1 Reconnecting with a childhood religious identity

For those who did have a sense of religious identity (dormant or active), recovery involved reconnecting their lives with that identity. Going to Mass, and especially singing in the choir, helped Jo to connect with her childhood. She describes this in the following quote. I had just asked her how important her belief framework was in her recovery.

It was very important. It gave me a sense, em, I'm one of these people that would go to Mass three weeks in a row and then not go in three years, but... when I got into AA, after I'd stopped smoking as well, that was my reward, to go and audition with the cathedral choir, so I did that and that gave me a bit of self-esteem, connecting, again connecting right back to my childhood, to really happy memories, of singing the Latin Mass and all that kind of stuff, and that was a connection. (Jo)

Jo had been brought up in a Roman Catholic culture and she associated her childhood practice of singing Mass with positive memories. Singing Mass corporately and privately became a powerful resource for Jo in her recovery. It gave her a connection with positive memories and also with her God. Reconnecting with these practices became a fundamental part of rebuilding her life and establishing her recovery identity.

Catherine also talked about being connected to her Roman Catholic identity. The following quote is her response to my question, 'would you say that [going to church] was an important part of your recovery?'

It was very important . . . I think, you know, it was important because it gave me some stability. And also connected to a part of me that was the Catholic. I think it was just . . . it was safety and it was comfort. It was like, "I'm now really straight" (whispered). I remember going to chapel on a Sunday . . . wheeling my daughter, feeling like, "Oh I feel safe now in the world" (whispered). So I was very much a member of . . . from a big Catholic family, so a lot of approval around that, I got. So a lot of it underneath was having...I suppose was trying to pay back, "I'm okay now, everybody. I'll show you how okay I am. Here's how I'm okay - job, life . . ." (Catherine)

Catherine's habit of going to church connected her with the community of which her family was part. It connected her with a Catholic identity through which she gained a sense of feeling safe and comfortable. Catherine emphasised this point in a further statement.

Yeah, it was part of . . . you know, you went to the chapel every Sunday. You know, it was the start of your week. You felt quite good. It was embedded . . . ingrained in me, from a child, you know. It was safety. It was connection. It was acceptance. It was...you know, all that. I got...you know, I used to feel safe. It was linked to safety, you know. I was back being normal, you know, there was all of that in it. Accepted. (Catherine)

By being part of the church community Catherine established a new 'straight' identity for herself. This was in contrast to her previous 'deviant' identity. Her new identity was reinforced through the social approval she gained in the community. She also suggested that her involvement in the community was about payback, because of the help that she had received from her devout parents and a Roman Catholic priest while she was in prison. Her involvement was motivated in part by social expectations and in part by guilt. Her phrase about showing people that she was okay suggests that she was performing to gain social acceptance. Going to church was part of her broader

reformed lifestyle which included having a job. From a practical vantage it gave her a sense of stability and a positive routine. Catherine's identity in early recovery was tied up with her identification with Roman Catholicism. This, however, changed as her recovery evolved. I will return to this in chapter 9.7.

9.2 Re-constructing a religious/spiritual identity

For some participants, identity construction in recovery involved re-constructing a religious identity and forming an alternative spirituality. This was evident in Amy's case. Amy had maintained her Roman Catholic faith during her phase of problematic substance use. She attended Catholic chapel despite feeling some discomfort because of what she described as her 'fear of letting go'. A central part of Amy's new recovery identity was re-constructing her understanding of her God/higher power. She continued to attend Catholic chapel, but she explored her Christian spirituality through going to other denominations. Her new spirituality emerged through her exposure to Twelve Step spirituality. In the following quote, she makes a distinction between the religion of her family background and the faith of her own choosing.

I work a Twelve Step program . . . you know like going through the steps. And that's been good, just getting rid of all that baggage as well. Eh, I suppose that will come into my beliefs as well, and I believe in a higher power and things like that, believing in a higher power. Which I really struggled with, because I was brought up a Catholic, but that wasnae through choice, I think I was about 6 months [old], you know you get baptised, get confirmed and things like that. That wasnae really through choice you know, it was like, my family, it was my family, I was brought up a Catholic . . . I do believe in God, but it's my God now, it's my God of my understanding (laughs). (Amy)

When I asked Amy what her spirituality meant, she said that her first spiritual experience was 'putting down the drugs' and getting clean. The outcome was having a clarity of vision and a sense of being 'awoken'. She went on to explain that her spirituality was about following God's will and moving on from the person she used to be.

And maybe just like, [spirituality], you like having God's will rather than my will, cause, you know I wasn't a nice person out there, even though it was survival it still wasn't God's will to lie, cheat, steal and things like that. So, I don't run on my will anymore, d'you know what I mean? I do what, you know, turn that [hate into love], having compassion for people, and things like that. (Amy)

Amy's new spirituality involved letting go of her old self, which she saw as immoral, and following God. She implied that she saw her own will as corrupt. In her new spiritual identity, she followed new moral values, such as love and compassion. Amy's new spirituality had its roots in Roman Catholicism, but her exploration of Christianity through other denominations broadened her spiritual identity. Her new spirituality was also influenced by the ideas she encountered in NA. This allowed her to explore what the God of *her* understanding might be. Amy re-constructed her spiritual identity by drawing on her Catholic background and reinterpreting her spirituality through Twelve Step spirituality. This freed her to explore other expressions of spirituality that fitted with her Christian belief system.

9.3 Establishing a religious/spiritual identity

Both Ewan and Rachel developed religious/spiritual identities during their phase of problematic substance use (Christian and Buddhist, respectively). While the beliefs and practices that they gained enriched their lives during this time, they did not have any profound, immediate impact on their substance use, though, at least in Ewan's case, they contributed to his recovery journey (see Ch. 8.2). As their recovery developed, their religious/spiritual identities became more established, as they constructed their recovery identities.

Ewan's identity transformation was a very gradual process. He became a Christian some years before he achieved abstinence. He explained that during the early part of his 'Christian walk,' he was 'dabbling in Christianity'. Like Amy, he felt an incongruence between his Christian identity and his drug centred lifestyle. When in rehab he had a sense that one day, God would set him free. When Ewan left rehab and entered supported accommodation his support worker explained 'spiritual stuff' to him and this helped him to grow in his understanding and develop spirituality. He believed that God truly set him free at around six months after he became clean. Core to Ewan's new sense of self was freedom and choice to be himself. Previously he identified himself as the black sheep of the family and he described how there was a culture of alcohol misuse among his relatives. He did not want to conform to these roles, but instead, built his recovery identity around his Christian faith. When I asked Ewan how important his spiritual or religious beliefs had been in the whole scheme of his recovery he replied,

It's who I am. Very important . . . I work in the Christian recovery field. I feel like, for me as an individual, if I'm not able to express that my name's [Ewan]. I'm a recovering addict and I believe in Jesus, as my personal lord and saviour, then I'm gagged . . . I cannae separate it, Peter. I just cannae separate it. It's who I am . . . It's, for my whole life, it's my whole recovery is about, Christianity. My whole life is about Jesus. Jesus came to set us free. (Ewan)

Ewan used the metaphor of being set free to make sense of his recovery. He was implying that his drug-centred lifestyle was one of bondage, of slavery. Ewan's Christian faith gave him a framework in which to construct a new drug-free life. It provided him with a sense-making worldview that gave him a sense of worth, purpose and hope. Getting involved in Christian orientated social and practical activities (going to Bible college, attending church and working for Christian organisations) also helped him to establish and live out his new identity.

Rachel's Buddhism was already an element of her pre-recovery identity. Spirituality seemed to play some role in Rachel's early recovery, but it wasn't until after two years, from when she marked the start of her recovery, that her 'spiritual practice then paid off.' At this time, she devoted two years to pursue her spiritual practice.

I'd two years fully devoted to my spiritual practice, to discovering myself, and I found out I was a Buddhist, it was so lovely. (Rachel)

As her recovery became more established, Rachel's spirituality became more central to her sense of self. Like Amy and Ewan, she used her spirituality as a sense-making framework and a resource for a healthy lifestyle. Rachel, who also worked in the recovery field, elaborated on why she believed spirituality was important to recovery.

You cannot take someone out of a small life that we've made in addiction . . . you cannot take them out of that by offering them a life that is just as small. It's not possible. It's not about any particular religion, but they need to be able to ask the big three o'clock in the morning questions – Why am I here? What is this for? And what the fuck am I doing with my life? (Rachel)

Rachel's explanation clarifies that she believed that spirituality was important to recovery because it provided meaning to an otherwise potentially meaningless life. She seemed to be saying that spirituality provided a 'bigger,' more significant, more meaningful life in contrast to the 'small' life of addiction. This principle was reflected in how Rachel utilised spirituality in her recovery identity.

9.4 Discovering a new religious/spiritual identity

Identity construction in recovery could also be about discovering a brand new religious/spiritual identity. This was the case for Sean (Ch. 8.1) and David (Ch. 8.1; 9.7), and also Anna, who I will discuss here. Anna's personal belief system drew on ideas chiefly from Twelve Step philosophy and Christianity. The following quote from Anna illustrates how she used the idea of breaking down of the self to make sense of her new life and recovery identity.

I loved the new life. You know it was like "Wow." You know, and I suppose what I call, maybe it was just with the Twelve Step stuff, we called the breaking down ourselves. That's what I call it. The breaking down of self. All the old behaviours and conditions in me that I've come to see that I have to let go of, Peter, for the peace that I seek. And it works but it can be difficult, especially emotionally at times. (Anna)

Anna saw a clear distinction between her old and new self. For Anna, establishing a new recovery identity was about breaking down, or disassembling the old self, to make way for the new self. Anna adopted this idea from Twelve Step philosophy, but it also has roots in Christian theology. Anna's recovery identity was closely linked with her identification with Twelve Step fellowships, but she also saw her new self as intimately connected with her God.

So if Jesus Christ has got God within him, and I have, I'm coming to believe - if we've all got a bit of God within us is that the true transparent spirit? Is that the true self? Is the words and situations we have learnt fae we were that size, polluted us? Has it taken us that far away fae the truth which is God within everybody, that we're lost, that I was lost. (Anna)

Anna believed that part of God lived in her (and in everybody), and that connection with 'God within' was connecting with the true self. Later in our conversation she reiterated her belief that part of God is within her and every human being and that, 'when we connect to the truth within another person there's that connection, that's got to be God'. Anna defined her pre-recovery state as one of lostness³⁰. For Anna, establishing her new identity was about finding herself in finding God. In this way, her conception of self was bound up with her conception of God. However, she suggested on a number of occasions in our discussion that she was still exploring her understanding of God. In this sense, her identity was still in evolving.

³⁰ Perhaps a reference to the Biblical metaphor of lostness (e.g. the parable of the lost sheep).

9.5 Discovering a non-religious spirituality

A number of participants who were actively involved in Twelve Step fellowships constructed recovery-orientated spiritual identities that did not involve any association with traditional religious institutions. This was the case for Billie and Olly (also see David, Ch. 8.1).

Billie had numerous encounters with psychiatric addiction services and Twelve Step fellowships before she finally recovered. She came to a point in her life when she had experienced enough of the negative consequences that she related to her problematic drug use. Finding social support, knowledge and practical tools in NA, and therapeutic support from a friend supported Billie to change. Billie identified spirituality as an essential ingredient for her long-term recovery

I started asking for help and I kind of developed a higher power. It wasnae God-orientated or anything like that, it was just changing the way I done things. I changed the way I spoke to people, became very honest. Yeah, I started to change. I think I started to believe in myself. I think my self-esteem can still be low at times but it's far better than it was before. I think my confidence has grew, all of that stuff. (Billie)

Believing in a higher power became a core part of Billie's new recovery identity. Her spiritual identity also involved changing the way she related to people, following a new moral code. This in turn affected her self-esteem. Billie elaborated at another point in our conversation that practicing the principle of honesty and 'doing the right thing,' made her feel good about herself. Billie also believed 'the answers' to life's problems were within her and she could access these through meditation. She

elaborated, that the 'deeper level of consciousness' that she found through meditation helped her to 'keep going with what I need to do to maintain the person who I am today'. The spirituality that Billie found in her recovery helped her to construct a new sense of self, connected with a higher power, a spiritual community (NA), spiritual ritual (meditation) and a new way of behaving (right action).

Olly also found a new spiritual identity through NA. Olly's spiritual identity during his phase of problematic substance use was complex (see Ch. 8.5). He had been exposed to Christian ideas, literature and prayer through several short periods of residence in Christian-based rehabilitation facilities. He also had experiences of hearing voices while detoxing, which he interpreted as dark forces or the devil, possibly ordained by God. Olly's sustained recovery (3 years) was initiated through the support of an abstinence-based treatment programme centred around the Twelve Steps. Through the programme, Olly was instructed to find a higher power, to pray daily and to help others. He developed a spirituality that became a crucial part of his recovery experience and identity. He had a sense of a God that was on his side and present with him, as long as he was 'doing the right stuff'. Olly used prayer to connect with God and help him to cope with life's challenges. He described prayer as 'a practical part of my life, incorporated in a healthy way'. Olly's spirituality was rooted in his connection to AA, which he called his 'church'. Helping others in AA also became a core part of his new identity.

Olly described his sense of self before his recovery as, “You’re a piece of shit,” and he felt that every action was compounding this. He expressed how he was uncomfortable with acts, such as shoplifting, being lustful and compulsive, believing they were against his true nature. He saw his spirituality freeing him up to be a better person, to ‘be the person I’m supposed to be’. He related his new sense of self to helping others and new spiritual principles which he learned at AA and sought to practise in his daily life.

This spiritual path that was outlined involves me being brave, courageous and faithful, in the midst of all the madness . . . I had to try and be humble. I had to be honest. I had to be willing to do what I’d not done before. (Olly)

9.6 Assembling secular identities

Identity construction or re-construction was also highlighted as being important for some participants with secular belief systems. The clearest examples were Jasper and Paul. Jasper believed that admitting he was an alcoholic was the first step to his recovery. Developing a clear sense of self seemed to be a crucial part of Jasper’s recovery. As part of an affirmation exercise that Jasper undertook during his recovery therapy, he recollected a memory of being on a hill when he felt he was his true self:

I sat up there. It was fantastic. I was [Jasper] and I wasn't brother, son or anything like that. I was just [Jasper]. And I just had kind of an epiphany moment, and I wanted to go back and see what it was like, sober. So that was one of my affirmations, so I'll go there next year. (Jasper)

During his recovery Jasper looked back to who he used to be before alcohol was the defining feature of his life. His goal was to become that person again. He indicated this when he stated, 'in my recovery, I certainly found myself again.' It was also important for Jasper that he didn't always want to be defined as a recovering alcoholic. He wanted to be 'Jasper'.

Recovery is finding out that the [Jasper Jones] is a really caring, intelligent, insightful, loving person. I love it! I love being me, I love being [Jasper]. I love being myself again. Truly, it's a really powerful, gorgeous feeling, so it is. Life is good! It is . . . Recovery is, I've got my life back, I've got my life back and I've got me. (Jasper)

I questioned Jasper further about his statement and whether he was talking about his true self, somebody he used to be or something else. He was clear that he believes that he found the person of his youth, not another 'me', but simply 'Jasper'. Recovery for Jasper was about being his true or essential self and reclaiming his life. Jasper also connected his true self in recovery with his volunteering and caring for others, especially helping people in recovery. In relation to these activities he used the term, 'I found that's who I'm like'. In addition to returning to the person who he believed he was, he portrayed a sense of finding out who that person is – a process of self-discovery. Jasper's volunteering and helping others also suggested a sense of pride in the achievements of his recovery. Jasper's recovery, as he portrayed it, was essentially about reclaiming an idealised version of himself. Jasper also made use of spiritual rituals (meditation, Qigong and acupuncture) within his secular framework. These rituals gave him a sense of peace, and connection with the universe and with his true self.

[Jasper], just being me, I love the idea of that, and that, to me that's [spirituality] . . . Just feeling really one, just feeling, "[Jasper's] here, it's fine, everything's okay," and relaxed. I think with the drinking and the recovery, there's never a time to relax, and I've got to the point where now I can relax. (Jasper)

Identity transformation was also apparent in Paul's account of recovery. Paul's sense of self seemed very important to him as he contrasted how he perceived himself before and after his recovery. This is how he described his self-attitude during his problematic substance use:

I didnae believe in myself, I wasnae confident in myself. Because, when I used to live in my flat, all my mirrors were down when I was drinking, I could not look at myself at all. I hated what was looking back at me, hated it and it was just a nightmare. I'd a big beard and everything. I just could not look at myself at all, I hated who I was. (Paul)

Paul describes how he had no self-belief, no confidence and how he hated who he was. In contrast, Paul defines his self-attitude during his recovery by his belief in himself. He believed that previously he was trying to please everybody else and he forgot about himself. His recovery was about doing it for himself:

This is about me, you know what I mean? I was trying to do it for my mum, I was trying to do it for my kids, come off the drink. I was trying to do it for everybody and I did, I clean forgot about me. And, that was the day, it was like, sit up and take a look at yourself, you did forget about you. It has to be for me, you know? And, that was a big wake up call, definitely. (Paul)

Paul's sense of self-worth developed as his recovery developed. Through attending an addictions support group, he realised that he wasn't the only one going through

an 'addiction' (his word). After about a year of abstinence he started to volunteer as a peer support worker. His experiences in this role bolstered his new identity further. Paul talked about giving a speech in the addiction service he volunteered in and made the point that before his recovery he would never have been able to do this. He also shared an account of inspiring one of the men that he supported:

He says, "you ken something, [Paul], you inspire me so much that I dinnae want a drink anymare". And, he's been sober now for nine and a half months. And, even to hear that. Because, I'm not one of them, I didnae like compliments before. If anybody said, "oh, you're looking great" . . . "Get away," you know? But, when he said that, it sort of touched me. It was like, well, if I can inspire one person, that's my job done, basically. (Paul)

Before his recovery Paul had a low sense of self-worth. Through changing his lifestyle and especially through getting encouragement from helping others, Paul's self-esteem was transformed. Paul believed he had been an 'alcoholic'. He also believed that he couldn't return to social drinking. In this sense he believed that he was 'still in recovery'. What seemed to be at the heart of his new identity was his new sense of self as someone who was a helper and inspiration to people seeking to recover.

9.7 Evolving identities

The construction of identity during recovery is a fluid process. An individual's identity can be transformed suddenly or evolve gradually as recovery develops. This may range from relatively minor changes, to the person having a crises of identity. Catherine and David both shared how their stable recovery (or post-recovery) identities were markedly different from their early recovery identities.

Religious/spiritual beliefs were very important to Catherine and David in their early recovery. Catherine's Roman Catholic identity allowed her to re-connect with her family and the community, gave her a sense of safety, stability and normality (see Ch. 9.1). David's spirituality, centred on Twelve Step fellowships, gave his life a new meaning and purpose (Ch. 8.1).

Both Catherine and David moved away from their religious/spiritual identities as their recovery developed. Catherine's move away from Roman Catholicism began with a discomfort with certain Catholic values that did not fit well with her identity as a single mother. She used her education and work and ideas of feminism and psychology as alternative building blocks for her evolving identity. She also re-constructed her spirituality around Buddhist ideas and practices. This too evolved as she became disillusioned by the religious elements of Buddhism, choosing to adopt a humanistic version of Buddhist thought and practice.

David started to doubt his idea of God and found he could no longer fit in with the culture of NA. He still wanted to maintain spiritual practice and, like Catherine, found this in secular Buddhist meditation (mindfulness). Interestingly, both Catherine and David were educated in therapeutic professions (social care, social work, addiction and psychotherapy). Catherine's spiritual identity evolved gradually but it was after about five years that she moved away from Catholicism. David's move away from his theistic beliefs also happen gradually but happened later after ten years. Both seemed to experience some degree of identity crisis. Catherine's and David's example

illustrate that religious or spiritual beliefs may be especially helpful in the initiation and sustaining of recovery, but once recovery has been stabilised, other ways of thinking and behaving can appear more relevant.

9.8 Conclusions

The cases that I have described in this chapter illustrate the different ways that individuals construct or re-construct their identities in recovery. Jo and Catherine developed their recovery identities through re-connecting with the religious beliefs and practice of their childhoods and family. They did so in different ways. For Jo it seemed to be about a very emotional and spiritual connection, while Catherine emphasised the social aspect of her Catholicism. The differences between Jo and Catherine are perhaps indicative of Jo's past use of a socially acceptable drug (alcohol), and Catherine's past use of 'illicit' substances and her 'deviant' lifestyle.

Amy's recovery identity was also connected with her family's Roman Catholicism. However, during her phase of problematic substance she maintained her practice of attending Mass, despite feeling uncomfortable at times. She re-constructed her spirituality through involvement with NA and finding the God of *her* understanding. This included exploring other expressions of Christianity and adopting the moral values of NA. She expressed a clear contrast between the person she was and the person she had become.

Ewan and Rachel established the spiritual identities they had discovered during their problematic substance use. Both integrated Twelve Step approaches into their personal belief systems in their early recovery. Their religious/spiritual beliefs did not enable their recovery in a direct way, but they became resources for transformation as their recovery developed. This suggests that religion/spirituality may be especially helpful for sustaining and stabilising recovery, or as Rachel put it, to answer the big questions of life: 'Why am I here? What is this for? And what the fuck am I doing with my life?'.

Anna, Sean and David all appeared to discover brand new religious/spiritual identities in their early recovery. All three combined Christian spirituality with Twelve Step involvement. All also had reached very low points in their life – what AA would refer to as 'rock bottom' experiences. Their new belief provided an alternative to their self-destruction, giving them resources for purpose, hope, meaning, community and a new way of life. Interestingly, they all had some kind of transcendent experience that prompted them to become Christians. Their spiritual identities were fundamental to their recovery experiences. However, they acknowledged that their identities were still evolving as their recovery progressed.

Billie's and Olly's non-religious spirituality was connected to their Twelve Step fellowship involvement. Both saw their spirituality as fundamental to their recovery identities, yet what they believed in seemed to be more fluid and less well defined than others' personal belief systems. Billie in particular seemed to borrow ideas from

disparate cultural belief systems and alternative philosophies. Like Amy and Anna, she emphasised the difference between her moral values during her problematic substance use and during her recovery. She saw herself as a different person in how she acted and related towards others.

The secular recovery identities that Jasper and Paul assembled were centred around their view of themselves, and in Paul's case, his self-concept in relation to others. Jasper sought to re-construct his identity in the image of his past, unsullied self. Rational thought and secular spirituality were a part of his identity. Paul's sense of self was developed through his relationship with his recovery community. Though finding acceptance and a sense of self-worth in his community he assembled a positive sense of self.

Catherine's and David's examples of later recovery illustrate how recovery identities evolve as personal belief systems evolve. They also illustrate the interconnectedness of identity with community, ritual and meaning-making. Both experienced a clash between personal identities and collective identities. Catherine's move away from her Roman Catholicism identity meant looking elsewhere for community, ritual and meaning-making. Finding community through her education and employment offered her alternative communities where her emerging values fitted better. She looked for an alternative spirituality in 'religious' Buddhism, and eventually seemed to find it in secular Buddhist thought, community and ritual. David's identity crisis was a crisis of meaning-making that impacted his identity as someone who believed

in God. He found he could no longer engage with the Twelve Step communities that were once a central part of his life. He was forced to look elsewhere for community, meaning and spiritual rituals.

10 Discussion

In this thesis, I have sought to shed some light on the role that religious, spiritual and secular beliefs play in pathways to recovery from problematic substance use, for individuals living in Scotland. In this final chapter, I will address my primary research question, ‘What role do beliefs play in individuals’ experiences of recovery?’ by presenting and analysing the key findings of this thesis. I will also address the implications of my findings for social work research, policy and practice. I will conclude by providing some final reflections on the research process.

10.1 The role of beliefs in recovery

The key findings of this thesis complement and confirm many of the findings of the existing evidence-base for recovery in Scotland, as outlined by Best et al. (2010), who suggested that pathways to recovery are diverse ‘spanning secular, spiritual and religious frameworks of personal transformation . . . and personal styles of recovery’ (25). My thesis has sought to elaborate the dynamics of beliefs and recovery through providing original, Scottish-based, empirical evidence.

Recovery pathways and belief systems

While Best et al. (2010) acknowledge the diversity of recovery pathways and styles, my research has shown that it is overly simplistic to assert that recovery pathways fit neatly within religious, spiritual or secular frameworks. The various interpretations, expressions, and combinations of types of beliefs makes such delineation artificial.

The evolution of personal belief systems through the stages of recovery also makes it difficult to categorise a person's recovery pathway as religious, spiritual or secular. The concepts of cultural and personal belief systems provide a theoretical framework for understanding the dynamic and fluid ways in which people adopt beliefs in their recovery. This theoretical framework may be particularly useful in facilitating a better understanding of 'cultures of recovery' that vary between local and national contexts. It may also be useful in broader sociological studies of beliefs in postmodern cultures, where the conceptual categories of religion and spirituality are too restrictive.

Community

My research has shown the importance of engaging with communities where people share a common cultural belief system. Best et al. (2010) also acknowledge the benefit of 'participation in a community of shared belief (e.g. secular, spiritual, or religious recovery support fellowships)' (31). Existing research has emphasised the role of recovery support fellowships, especially Twelve Step fellowships, but also secular alternatives (e.g. SMART) (Best, 2014). My research has confirmed this, but also highlights the important role that religious/spiritual communities (churches, meditation centres etc.) can play in supporting people in recovery. It has also shown that different types of community can be important for individuals at different stages in their recovery. Recovery support fellowships can be crucial in the early stages of recovery, while religious/spiritual communities may be invaluable in stabilising and sustaining recovery. Buddhist communities may have particular relevance for people who want to pursue spirituality while maintaining a secular/atheistic belief system.

This research has also indicated that engaging with recovery-orientated or belief communities is not a universally positive experience. Communities can be socially alienating environments for individuals with contrary belief systems, prompting them to disengage. This may result in a temporary setback in their recovery until they find a more amenable source of social support. For some, it could affect their recovery detrimentally in the long-term.

Personal rituals

Best et al. (2010) refer to finding new daily rituals to maintain recovery. They take this idea from largely theoretical ideas proposed by William White (1996). This project has provided evidence which illustrates the importance of routine rituals for people in recovery in Scotland. Ritual practices ranged in their level of importance between individuals and between stages of recovery. Some saw their rituals as fundamental to their recovery, while others saw them as generally helpful. Routine rituals provided individuals with regular practices that were an alternative to their former drug-using rituals. They also functioned as a means to exploring or reinforcing (constructing) their personal belief systems, or specifically, to develop their spirituality.

Constructing meaning

The evidence-base for recovery suggests that finding meaning and purpose is an important part of recovery (White, 2008a; Slade, 2009; Best et al., 2010), and that religious, spiritual and secular belief pathways provide 'sense-making frameworks for change' (Best et al., 2010: 27). My research has honed in on the meaning-making

processes that individuals in recovery adopt in relation to their beliefs. Each participant interpreted their recovery experiences through the lens of their personal belief system, using it to make sense of experiences and give experiences substantive meaning.

Using personal belief systems to construct meaning was an important way of coping with and building resilience in the face of stressful or traumatic situations associated with problematic substance use and/or recovery. This was pertinent in situations where individuals were forced to face their own mortality. Religious/spiritual beliefs proved to be particularly helpful at these times because they could provide a framework for a new beginning, a new way of life, and deeper purpose, hope and meaning. They provided sophisticated philosophies, theologies, narratives and traditions through which individuals could find meaning in their lives. Others found meaning in their secular or secular/spiritual belief systems but they may have had to work harder to construct a personal belief system that provided the resources they needed to cope and build resilience. However, some individuals struggled with some of the doctrines and practices of specific religious/spiritual cultural belief systems (including Twelve Step philosophy). These difficulties prevented them from engaging fully, sometimes causing existential crises (minor or major), leading them to look elsewhere for beliefs and practices to support their recovery.

My research also illustrates how people in recovery construct meaning through constructing personal recovery narratives. My participants borrowed from the

language and concepts of the cultural belief systems that they adopted. There has been a notable amount of research conducted around recovery narratives influenced by Twelve Step philosophy (e.g. Jensen, 2000; Cain, 2001; Weegmann and Piwowoz-Hjort, 2009). This was confirmed in my research as several participants drew on Twelve Step language, concepts and narrative forms. My research has also revealed the presence of Christian narrative metaphors, such as rebirth and salvation. These were adopted by participants from a range of belief perspectives. This may highlight the influence of Christian ideas in Scottish culture and particularly on recovery culture, perhaps pointing to the historical roots of the Twelve Steps or the legacy of the Scottish temperance movement.

Constructing identity

My research supports and enriches the existing literature on identity construction in recovery (e.g. Biernacki, 1986; McIntosh and McKeganey, 2000). It sheds light on the different ways that individuals construct or reconstruct identity in recovery and highlights the place of religious, spiritual and secular beliefs in this process. Using the theoretical framework of cultural and personal belief systems, I illustrated how recovery identities are constructed through engagement with communities of other *believers*, where beliefs, behaviours, morals and values are learned and reinforced. Recovery identities are further verified through the personal practice of rituals and morals/values in daily life. My research supports the existing literature on social identity formation (Best, 2014) but also shows how identities are forged and reinforced through personal practice.

Cultural belief systems as recovery capital

Generalising about the value of religious, spiritual or secular beliefs in recovery is problematic because of the variations in how beliefs are adopted and practised. However, my research suggests that cultural belief systems can be invaluable sources of recovery capital (White and Cloud, 2008; Cloud and Granfield, 2008). Much research has been devoted to studying social/community recovery capital (Best, 2014), while cultural and personal/human recovery capital has generally been overlooked. My research provides insight into cultural capital in terms of cultural belief systems. It has also highlighted the significance of personal/human recovery capital in terms of individual's existential beliefs, which provide them with self-worth, hope, purpose, meaning and identity. Conceptualisations of recovery capital have also neglected the place of personal cultural practices. My research suggests that personal rituals could also be thought of as a form of recovery capital.

Beliefs and recovery in the Scottish context

In my initial investigations into beliefs and recovery I noted that much of the research came from North America. One of my original aims was to get a better understanding of the cultural trends of beliefs and recovery in Scotland. My small sample size and confined geographical focus has given me an in-depth but limited picture. My research has shown the central role that Twelve Step fellowships play in Scottish recovery culture. This was unsurprising as these are prominent in Scottish recovery culture. The spiritual programme of the Twelve Step was interpreted in religious, spiritual and secular ways. Christian churches also played a significant role for several

people. It may be that members of the Scottish recovery population are more religious/spiritual than the general population because Twelve Step programmes encourage a spiritual path. The presence of Buddhism or Buddhist philosophies among my participants may be reflective of a growth in interest in the general population, or may point to a special interest among people in recovery. Naturalism was the most clearly articulated secular belief system. It may be that it is more difficult to maintain a secular belief system in recovery culture because of the influence of Twelve Step spirituality. The growth of secular recovery support groups could counter this.

10.2 Implications – research, policy, practice

Research

This thesis has presented an exploration into the role of beliefs in experiences of recovery from problematic substance use in the Scottish context. It has provided a conceptual framework and highlighted some of the relevant themes and processes that could become the basis for further research. To gain a better understanding of the role of beliefs in recovery, more qualitative and quantitative research is required.

Further qualitative research could focus on the impact of different types of cultural belief systems on recovery culture. The influence of Buddhism on recovery culture in Scotland would merit further research in particular. While my research provided a general introduction to the influence of Christianity on recovery culture in Scotland, it would be interesting to find out more about the impact of different Christian sects

or theologies adopted by people in recovery. Ethnographic methods may be appropriate for investigating how different spiritual or religious beliefs or practices affect recovery communities, for example, participant observation in a Christian recovery support group or a meditation group. Such studies could focus on specific components of cultural belief systems (e.g. language, values).

My research highlighted the reporting of transcendent and/or hallucinatory experiences among participants, related to substance withdrawal and mental health. This phenomenon would merit further study to facilitate a better understanding of the psychological/spiritual processes that people go through in the early stages of recovery. In my research I was unable to address the variations in the beliefs and recovery experiences of people in ethnic minority groups in Scotland. Little is known about problematic substance use and recovery among ethnic minority groups in Scotland (EMEDI, 2006) and this area would be worthy of investigation as it may be the case that the needs of such populations are being overlooked by social work services.

The themes and concepts that have emerged from this research could also be further explored through a large scale quantitative study which could give a broader picture of the types of belief important to people in local communities across Scotland. This would be valuable in indicating the prevalence of different types of belief and in determining trends of belief between different local contexts. Beyond the specific study of recovery, the concepts of cultural and personal belief systems could be

utilised in the research of beliefs, where traditional conceptualisations of religion may restrict how beliefs are formed and practised in contemporary society.

Only a few of my participants mentioned the detrimental effects of particular beliefs on experiences of recovery. The main themes that emerged were social alienation, guilt, shame and existential crisis. I was able only to touch upon these themes. Further investigation of social alienation may indicate why specific recovery resources or interventions do not work for some people. Understanding more about guilt, shame and existential crisis may help therapeutic workers to support people in recovery. Another theme that became apparent, which was outwith the boundaries of this study, was how sexual identity impacts on problematic substance use. More knowledge on this topic would also be valuable.

Policy

In this thesis, I noted that while *The Road to Recovery* (Scottish Government, 2008b) does not refer to the role of belief in recovery, a Scottish Government-commissioned report, *Research for Recovery* (Best et al., 2010), and the report of an independent enquiry on drug and alcohol problems in Scotland (Matthews, 2010), makes mention of the relevance of religious, spiritual and secular beliefs to recovery. I would suggest that future policy should acknowledge the significance of beliefs to recovery in Scotland, with specific reference to how this might impact on training and practice (see discussion below). These recommendations may be controversial for policy makers as spiritual and religious belief can be related to divisive topics (e.g. sectarianism, religious fundamentalism and terrorism, child abuse in Christian

institutions). However, they are in line with the Scottish Government's equality agenda (Scottish Government, 2016), the Scottish healthcare guidelines to recognise patients religious or other beliefs (Interfaith Scotland, 2007) and acknowledgement of the relevance of spiritual care in healthcare (NHS Education for Scotland, 2009).

Beliefs in recovery should also be part of the Scottish Government's research agenda. The *Scottish National Research Framework for Problem Drug Use and Recovery* (Scottish Government, 2015c) has proposed that future research needs to 'explore and test how people receive support which helps them to recover from problem drug use' (8). Beliefs are not mentioned specifically, but research in this area could be supported under priorities such as research into 'how communities work to promote recovery' (8). Where Scottish-based research on belief and recovery is not available, policy should draw on relevant research from other contexts, as it does on other aspects of recovery.

Practice

This research has illustrated the value that beliefs can have for people in recovery. If this is the case, social work practice should incorporate this knowledge into approaches for supporting people with substance use problems. Within the field of social work, various approaches have been developed in response to the assumption that considering religion, spirituality and belief is important to practice. In my discussion of social work and beliefs (Ch. 2.2.5), I noted that the two main approaches were firstly assessment, including formal tools and frameworks for practice (e.g. Hodge, 2001; Furness and Gilligan, 2010), and secondly, approaches that integrate

aspects of spiritual/religious philosophy or practice. (e.g. Kumar, 1995; Young-Eisendrath and Muramoto, 2002). It has not been within the aims of this thesis to evaluate these approaches. Many of these models are well developed and include many commendable recommendations which ought to be carefully and critically considered by social work practitioners. Equally, some approaches, particularly those which incorporate philosophies and practices rooted in specific cultural belief systems, may not fit well with secular social work practice that aims to be multicultural and transcultural (Holloway and Moss, 2010). It is also beyond the scope of this thesis to develop a new model for integrating beliefs into social work practice. Instead, I will highlight key social work practice principles/approaches which are implied by my findings and discuss the practicalities of implementing them.

Holistic practice (Payne, 2005; Galvani and Forrester; 2011a)

Social workers ought to consider the whole range of influences that impact on people's lives, including their religious, spiritual and secular beliefs and practices. This might mean carrying out an assessment of beliefs or referring individuals to services or communities where they can explore or develop their beliefs. Carrying out holistic principles in practice may be challenging for many social workers for three key reasons: the secular traditions of social work; the demands of new public management; and resistance from social workers with incongruent beliefs.

Firstly, while social work in Scotland is rooted in the Christian tradition, modern social work practice has developed secular traditions (Cree 1996; Payne, 2005). Some

voluntary sector social work services with religious roots are an exception to this rule. Statutory 'secular' social work services may be particularly wary of stirring up religious controversy or being open to the accusation of supporting a proselytising approach. Social work service providers in Scotland are also likely to be acutely aware of: sectarianism in Scottish society; abuses of religious power in connection with child abuse by Roman Catholic clergy; and the radicalisation of young Muslims by so called Islamic fundamentalists. While there may be more openness to spirituality in social work, including any aspect of religious belief into practice is likely to be highly controversial (Crompton, 1996; Gilligan, 2003).

Secondly, trends of new public management (Gruening, 2001) mean that employers are required to be interested in measurable outcomes. People's beliefs, particularly religious and spiritual beliefs, do not easily fit within this framework and are therefore not usually a priority for employers. The demands of new public management, along with funding pressures, mean that social workers are often burdened with heavy caseloads and have limited time to engage with service users. Exploring beliefs with service users may not be considered a priority compared to more practical matters and immediate needs.

Thirdly, individual social workers may feel uncomfortable talking about beliefs because their own beliefs may be incongruent with those of service-users (Crompton, 1996; Gilligan, 2003; Furness and Gilligan, 2010). One of my research participants, who was also a recovery worker, suggested the health professionals she had

encountered were challenged and offended by the reference to 'God' in recovery training events (e.g. in the Serenity Prayer). She suggested that there was a secular/spiritual divide and a 'culture of quite strong alienation' between addiction professionals and recovery communities. She thought that this alienation was due to professional's 'strong divorce from their emotional and spiritual aspects of their humanness'. She believed that because professionals had no personal sense of spirituality they were restricted in their ability to help people in recovery. She also suggested that professionals confused spirituality with religion in their perception of Twelve Step fellowships. Research by Day et al. (2005) has suggested that many substance misuse workers are ambivalent towards or disagree with Twelve Step philosophy, making them hesitant to refer service users to Twelve Step groups. The principles/approaches of cultural competence, as discussed below, may be a step towards countering the resistance that some social workers have towards religious or spiritual recovery interventions or resources.

Ethical practice (Butler, 2002; Banks, 2012)

Any inclusion of beliefs into practice should be done so ethically, ensuring that social workers are not abusing their position of power. Not all participants, including some of those with strong religious beliefs, thought that beliefs should be incorporated into practice. A service-user's consent should be sought before assessment of belief or any belief-related intervention is carried out. Any belief-related approach should be subject to ethical evaluation and review by service providers, who should also provide guidelines for good practice.

Anti-oppressive practice (Dominelli, 2002; Thompson, 2006)

A number of participants talked about the harmful or challenging impact of their beliefs on engaging with belief communities. Examples included feelings of social alienation, guilt, shame, or experiencing an existential crisis. While the benefits of beliefs should be acknowledged by social workers, so too should the potential for suffering and abuse (Holloway and Moss, 2010). Helping service-users to avoid harms related to either their beliefs or to those within their belief-communities is ethically challenging. My research does not provide an answer to how this should be achieved, however, I would suggest that such harm can only be revealed and tackled sensitively through developing a trusting relationship with service users (Ruch et al., 2010). Social workers may also be guilty of harming service users in relation to their beliefs (e.g. through discrimination, spiritual or religious abuse). Social workers and social work services need to be aware of how their peers and employees are engaging with service users on the level of beliefs and ensure that they are not exploiting their positions of power. This applies especially to any form of spiritual intervention that may be practised in the workplace (e.g. prayer, meditation, reiki).

Cultural competence (Amodeo and Jones, 1998; Furness and Gilligan, 2010)

Cultural competence can be thought of as,

the ability of professionals to function successfully with people from different cultural backgrounds including, but not limited to, race, ethnicity, culture, class, gender, sexual orientation, religion, physical or mental ability, age, and national origin (Kohli et al., 2010: 257).

Social workers in Scotland need to develop cultural competence to work with a diverse range of people. My research supports the notion that there are cultures of problematic substance use and recovery in Scotland that social workers need to become familiar with (White, 1996). These cultures exhibit some common cultural beliefs systems. Social workers who regularly work with people with substance use problems should develop cultural competence particularly towards cultures of problematic substance use and recovery (Amodeo and Jones, 1998). This would include gaining a knowledge of the cultural belief systems that are common with these cultures, including related communities, language, narratives, philosophies, values, practices and behaviours. Cultural competence will also incorporate a strength-based approach, being reflexive and being person-centred and relationship-based (discussed below).

Strengths-based practice (Weick et al., 1989; Saleebey, 2012)

A strengths-based perspective complements cultural competence. This has been suggested by Harvey et al. (2010), who argue that it is the responsibility of social workers 'to understand culture and its function and to further recognise the strengths that exist in all cultures' (70). While the strengths-based perspective is well established in social work literature, systems of social work practice may bias workers towards pathologising and stigmatising service users (Llyod, 2010; Singleton, 2011). Religious belief in particular may be seen as potentially negative (as discussed above). While the negative effects of certain religious beliefs and practices need to be taken

into account, social work needs to move beyond its secular bias and acknowledge that religious and spiritual beliefs are sources of strength for many people.

*Reflexive practice*³¹ (D'Cruz et al., 2007)

If social workers are to support service users in exploring or strengthening their personal belief systems, then they must have a good awareness of their own beliefs.

Reflecting on one's own beliefs in relation to the beliefs of service users is part of being culturally competent. Kohli et al. (2010) notes that,

Cultural competence begins with an awareness of one's own cultural beliefs and practices, and the recognition that others believe in different truths/realities than one's own (257).

This is also proposed by Furness and Gilligan (2010) in their model of cultural competence. They observe that practitioners need to be 'self-aware and reflexive about their own religious and spiritual beliefs, and their responses to the religious and spiritual beliefs of others' (44). This is a practice that should begin in the education of social workers.

Person-centred / relationship-based practice (Rogers, 1951; Ruch et al., 2010)

People in recovery draw on conventional cultural belief systems, but they interpret, practise and combine beliefs in individualistic ways. It is therefore not enough to have general knowledge about cultures of problematic substance use and recovery. Social

³¹ See chapter 3.1 for my discussion on reflexivity.

workers should be careful about jumping to conclusions about individuals' beliefs. In order to understand someone's personal belief system and provide tailored support for that person, social work should be person-centred and relationship-based in its approach. This will involve building trusting relationships with service users, listening attentively and respectfully to them and taking time to hear their beliefs and their unique stories of belief, acknowledging that individuals are experts in their own lives. Since recovery is often a circuitous and drawn out process with many emotionally challenging events, social workers need patience and compassion to maintain relationships with service users. Such service users need social workers to not only be professionals and experts, but to be friends to walk along-side them on their journey (Dybicz, 2012). Social workers can become part of individuals' recovery and belief narratives helping them find meaning in the face of challenging events, helping them to explore and establish recovery identities and supporting them to engage with supportive communities and meaningful personal rituals.

Summary

In response to my findings, I have suggested that social work practice should consider how service users with substance use problems can be best supported in terms of their beliefs. I have discussed how this might be achieved in terms of core social work principles/approaches: holistic, ethical, anti-oppressive, culturally competent, strengths-based, reflexive and person-centred/relationship-based. I have highlighted some of the challenges in integrating beliefs into social work practice. To overcome these obstacles social work does not need a major paradigm shift, but many social

workers may need to acknowledge and look past their belief bias (religious, spiritual or secular) and consider how they can best support service users in recovery.

10.3 Final reflections

When I began this PhD I came with many questions about how people recover and what role beliefs play in processes of recovery. Carrying out this research has given me a deeper insight into recovery, but many questions still remain. This research has indicated that the dynamics of recovery and belief are complex. I feel that in many ways I have only scratched the surface of this fascinating subject. However, I believe I have met my goal of producing research that examines recovery and belief in the Scottish context. My hope is that myself and others will carry out further Scottish-based research that will shed more light on recovery and belief – not just from the viewpoint of social work and the social sciences - but from a range of professional viewpoints and academic disciplines. However, studying this topic, particularly aspects of religion and spirituality, has made me more aware of the limitations of science. I will end with a quote from one of the participants, who expresses this idea, and also the pragmatism necessary for recovery and the hope that more will be revealed.

I'm still confused about everything . . . but more will be revealed . .
. . confused about my spiritual life, and my recovery and how it all
works. Fundamentally, I know what I have to do and I know that I'm
supported in that, but when I try and analyse it, I may be
misrepresenting how I actually feel, cause trying to verbalise it . . .
when I try and think about "why" it kind of loses the magic a bit.
(Olly)

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12 Appendices

12.1 Recruitment letter

To whom it may concern,

I am seeking participants for a research project exploring *pathways of recovery (secular, spiritual and religious) from problematic substance use in Scotland*. This project promises to be an important contribution to how people seeking to recover are supported and cared for by social work services in particular and drug and alcohol services in general.

I would be grateful if you would post the enclosed posters on prominent locations within your meeting place and draw attention to this project to any of your members, past or present.

Please note that the project will not be an evaluation of your organisation. Participants will be sought from a broad range of sources and will be interviewed as individuals rather than representing any particular group.

Please do not hesitate to contact me if you require further information.

Yours sincerely

Peter Hillen

PhD Student

12.2 Recruitment poster/ leaflet



Do you want to share your story of recovery?

Volunteers are needed to take part in a research project about pathways to recovery (secular, spiritual and religious) from problematic substance use.

Why take part?

This project promises to be an important contribution to how people seeking to recover are supported and cared for by social work services in particular and drug and alcohol services in general.

Am I eligible?

- Has the use of alcohol or heroin been a cause of major problems in your life?
- Have you been in recovery for more than 12 months?
- Are you 18 or older?
- Are you living in Scotland?

If you can answer yes to all of the above you are eligible to take part.

What will be expected from me?

You will be interviewed about your experience of recovery once and possibly for a second time. Further details about what is involved can be found by contacting Peter by phone or email.

Contact

Peter on d.p.hillen@sms.ed.ac.uk

12.3 Information Sheet

An exploration of pathways to recovery (secular, spiritual and religious) from problematic substance use in Scotland.

You have been invited to take part in a research project conducted by a researcher (Peter Hillen, PhD student) from the University of Edinburgh. This project is funded by the ESRC (Economic and Social Research Council).

What does the project involve?

If you agree to take part, you will be interviewed by the researcher for up to an hour.

If willing and able, you may be interviewed for a second time.

Interviews will be recorded using an audio recorder and the researcher will take some written notes. Audio recordings will be written-up and parts of the text may be quoted or referred to in a PhD thesis or other publications.

You will be asked questions about your experiences of recovery from problematic substance use. You will be asked about your views on 'recovery' and what types of factors may have helped or hindered your recovery. These may be your life experiences, personal habits, social or professional support. You will also be asked specifically about your cultural background and beliefs which may be secular, spiritual or religious.

What will be expected from me?

Participation in the project is entirely voluntary. If you do take part, you will be able to withdraw at any stage without being asked why. You do not have to answer any questions that you feel uncomfortable with.

How will the information be used?

This research will be used to compose a PhD thesis. It may also be used in presentations, academic journal articles or other publications.

Will my identity be protected?

Your name and contact details will only be known by the researcher. This information will be held in a password protected computer or secured locker. Other information that could identify you will be removed to protect your identity.

Will I be paid?

If you do take part you will be thanked with a £10 voucher. Travel expenses and child care costs may be claimed if appropriate.

What if I am unhappy with the way I am treated?

If you are in any way unhappy with your experience in this research project you can make a complaint by contacting Vivienne Cree [phone no.] or Angus Bancroft [phone no.] at the University of Edinburgh. If you have any specific questions about the project you can contact Peter on [phone no.]

12.4 Screening questionnaire

Name (preferred):	
Gender: M / F	Ethnicity / nationality:
How did you find out about this project?	
What age are you?	
18-30 31-40 41-50 51-60 61-70 71+	
What drugs or substances have been causes of major problem in your life?	
Alcohol / Heroin	
Cannabis / Cocaine / Crack / Benzodiazepines / amphetamines / solvents / ecstasy	
LSD / mushrooms / methadone / tranquilizers	
Others:	
How long did you have a problem with heroin / alcohol?	
Less than 1 year / 1-2 years / 3-4 years / 5-6 years / 7-8 years / 8-10 years	
Over 10 years / over 15 years / over 20 years / over 25 years / over 30 years	
How long have you been in recovery?	
Less than 1 year / 1-2 years / 3-4 years / 5-6 years / 7-8 years / 8-10 years	
Over 10 years / over 15 years / over 20 years / over 25 years / over 30 years	
What agencies have supported you with your drug/alcohol problem?	
Where in Scotland do you live?	
Do you have any physical or mental health difficulties that mean you require extra support?	
Yes / No	
What is the nature of your difficulty?	
What kind of extra support do you need?	
Do you have any additional communication difficulties that mean you extra support? (e.g. poor eyesight, poor hearing, language difficulties)? Yes / No	

What is the nature of your difficulty?	
What kind of extra support do you need?	
Suitable interview? Yes / No	for Contact:

Further demographics (to be asked during interview)

Employment Status	Unemployed / employed / self-employed Length of current status:
Usual type of employment	
Education – Level completed	GCSEs or O levels / A levels / HNC / HND / apprenticeship SVQ/NVQ / UG degree / Postgraduate degree

12.5 Consent form

An exploration of pathways of recovery (secular, spiritual and religious) from problematic substance use.

- I have read the project information sheet and been given the opportunity to ask any questions.
- I am willing to be interviewed and understand that I can withdraw from the project at any time without being asked why. I am also aware that I do not have to answer any questions that I feel uncomfortable with.
- I understand that if I disclose any information that indicates I am at risk of harm or of being harmed, or that I am harming someone else, that social services and/or the police will be informed. This applies especially to any information about child abuse or neglect.
- I am aware that my interview will be audio-recorded and written-up. This data will be accessible to the researcher and his two supervisors. Information from my interview will be used in publications and presentations. Personal details (name, contact details and other identifying factors) will only be known by the researcher.

I understand and agree to the above:

Participant's signature.....

Name (Print).....

Date.....

Researcher's signature.....

12.6 Interview schedule

Problematic Substance Use

- 1.1. Can you tell me about your substance use history particularly;
- 1.2. How your substance use became problematic?
- 1.3. What areas of your life were affected?
- 1.4. How were they affected?

Recovery

- 1.5. Can you tell me about how you recovered?
- 1.6. What does recovery mean to you?
- 1.7. What aspects of your life are different now and in what way are they different?
- 1.8. What made you want to change?
- 1.9. What helped you to change?
- 1.10. What, if anything, has made recovery more difficult for you?

Pathways – Secular and Spiritual and Religious.

Describe pathways and belief systems*

- 1.11. How would you describe your beliefs?
- 1.12. Where you brought up with these beliefs?
- 1.13. How have your beliefs affected your recovery?
- 1.14. Is community an important part of your beliefs?
- 1.15. Are there any particular habits or behaviours you practice related to your beliefs?
- 1.16. Have you experienced any particular emotional or spiritual experiences that have contributed to your beliefs?
- 1.17. Are there any aspects of your beliefs that have been unhelpful in your recovery?
- 1.18. Are there any other resources that have been important to your recovery?

Implications for Professional Practice

- 1.19. Should professionals pay more attention to individual's belief systems when supporting them in their recovery? If so, why and how?

* It has been said that there are many pathways to long-term recovery. Each person's pathway to recovery is influenced by the person's belief system or worldview. Beliefs systems are commonly categorised as secular, spiritual or religious.

12.7 Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol³² – that our lives had become unmanageable.
2. Came to believe that a Power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God as we understood Him.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics³³ and to practice these principles in all our affairs.

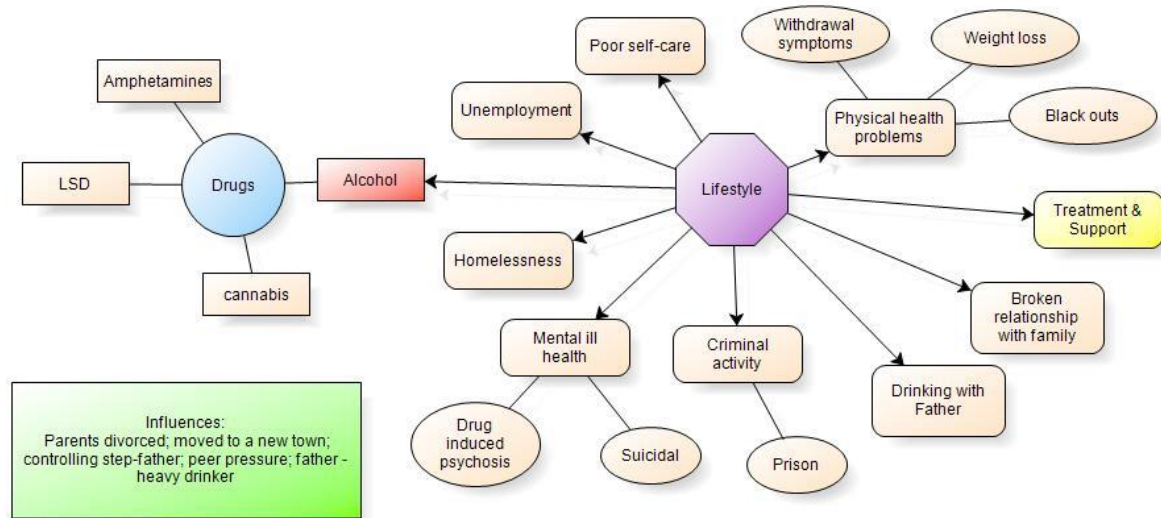
(Alcoholics Anonymous, 2013)

³² 'our addiction' in NA; <http://12step.org/references/12-step-versions/na/>

³³ 'addicts' in NA

12.8 Thematic maps (examples)

Problematic substance use



Recovery

